1995

Health Policy Below the Waterline: Medical Care and the Charitable Exemption

M.Gregg Bloche

Health Policy Below the Waterline: Medical Care and the Charitable Exemption

M. Gregg Bloche*

TABLE OF CONTENTS

* Professor of Law, Georgetown University and Adjunct Associate Professor of Public Health, Johns Hopkins University School of Hygiene and Public Health. B.A., Columbia College, 1977; M.D., Yale University School of Medicine, 1984; J.D., Yale Law School, 1987. I thank William N. Eskridge, Jr., Henry T. Greely, Daniel I. Halperin, Henry B. Hansmann, Susan Rose-Ackerman, and participants in Georgetown University Law Center's faculty research workshop for their helpful suggestions and comments on earlier drafts of this article. I am grateful to Robb Adkins, William Anderson, Joseph McNabb, and Michelle Cameron for their superb research assistance.

INTRODUCTION

For almost one hundred years, America's nonprofit hospitals have enjoyed nearly automatic exemption from federal income taxation. During this time, nonprofit hospitals transformed themselves from resting places of last resort for the sick poor into centers of high-technology intervention for all income groups. The financing of their services evolved in parallel, from primary dependence on the generosity of religious orders and charitable donors, to almost exclusive reliance on payments for services rendered. Meanwhile, the exemption's doctrinal underpinnings were repeatedly reinvented to accommodate change in the hospital industry's financial structure and social role. When Congress first enacted a charitable exemption to the income tax, including hospitals within its reach seemed an unexceptional instance of the exemption's availability to entities engaged in relief of the poor. Well into the 1950s, the Treasury Department continued to expect exempt hospitals to offer some free care to the poor, although it interpreted this requirement with increasing laxity. By the end of the 1960s, however, exemption of hospitals had lost all of its doctrinal moorings to either charitable giving or care for the poor.

In 1969, a landmark Internal Revenue Service ruling formally decoupled hospitals' eligibility for exemption from any obligation to provide free care for the poor. With only minor modifications, nonprofit hospitals today enjoy virtually per se

federal exemption. This per se exemption has been sharply criticized by advocates of charity care requirements and those who would prefer to put an end to tax exemption of hospitals altogether. Yet the exemption persists, protected politically by the interests that have come to depend on it and legally by the weight of decades of administrative and judicial precedent.

Moreover, the prospect of a large expansion in the exemption's scope now looms. The health care industry has entered a period of extraordinary change, marked by the rapid emergence of managed care networks that integrate the financing and provision of services. For the most part, insurers have driven this transformation by organizing such networks as a market response to employers' growing medical cost sensitivity. However, nonprofit hospitals have begun to develop competing integrated systems, perhaps looking both to lock in buyers for their services and to capture risk-bearing premiums traditionally taken by insurers. Not surprisingly, some of these nonprofit systems have sought tax exemption for their financial risk-bearing activities. Whether the exemption accorded to hospital services will be expanded to encompass financial risk bearing remains an unsettled question.

This Article examines the conceptual underpinnings of the federal tax exemption accorded to hospitals[1] and considers its

1. Internal Revenue Code § 501(c)(3) sets forth the exemption's statutory basis. This provision exempts corporations "organized and operated exclusively for religious, charitable, scientific . . . or educational purposes, . . . no part of the net earnings of which inures to the benefit of any private shareholder or individual . . . ." I.R.C. § 501(c)(3) (1994). Exemption of health care institutions under this provision has long rested on the claim that they serve "charitable" purposes. This Article focuses on this basis for exemption. I do not address the possibility, unsupported by IRS or judicial precedent, that some health care institutions (e.g., hospitals operated by religious orders or universities) could qualify for § 501(c)(3) exemption solely because they serve "religious," "scientific," or "educational" purposes. Absent IRS and judicial willingness to construe medical care as an entirely "religious," "scientific," or "educational" endeavor, this theoretical possibility would appear to be barred by the § 501(c)(3) exclusivity requirement.

Nor do I address the separate question of private inurement, because private inurement issues, typically arising from compensation and joint venture arrangements between nonprofit hospitals and staff physicians, have recently become a major focus of IRS attention. *See* Gen. Couns. Mem. 39,862 (Nov. 21, 1991), *reprinted in* IRS Pos. (CCH) ¶ 2327 (Dec. 6, 1991) (announcing new, more demanding private inurement and benefit standards, including the requirement that exempt health care providers adhere to federal Medicaid and Medicare anti-kickback laws). Although vexatious, these issues represent problems of application, distinct from the prior question of whether medical services merit exemption absent private benefit.

future evolution.[2] It evaluates a variety of approaches to understanding the exemption, both in its current form and as an entitlement refashioned along more restrictive lines.[3] Some of the approaches that I explore have been vigorously articulated elsewhere by academic commentators and interest group representatives. Others have been less well developed and I reformulate them here in order to assess their merits without pursuing possible straw men. Still others are set forth herein for the first time.

Some of these approaches represent efforts to explain the exemption's current form, while others are avowedly normative in thrust. Still other approaches straddle this line more or less awkwardly. The primary focus of this Article is the exemption accorded to hospital services. It also examines, however, the exemption's application to risk bearing performed by vertically integrated networks that both finance and deliver medical care.

A major purpose of this Article is to contribute to a deeper understanding of the federal exemption's actual and potential roles as an instrument of health care financing policy. Based on the understanding developed herein, I offer some recommendations about the form that the exemption ought to take. Beyond this, I propose a broader lesson about the limits of functionalist explanation and justification of legal arrangements that are tied to embedded patterns of economic and social reliance.

Part II of this Article sets up the problems of explanation and justification posed by the per se exemption by briefly tracing the IRS's failure to develop a plausible rationale for hospital exemption. Part III considers several alternative rationales for per se exemption of nonprofit hospitals. First, I assess the Treasury Department's recent claim that the exemption functions as a social welfare-enhancing quid pro quo for nonprofit hospitals' production of positive externalities. After finding this line of argument wanting, I construct a case for per se exemption based on Henry Hansmann's model of charitable exemption

2. Although many of the arguments considered below also bear upon state and local tax benefits available to hospitals (e.g., exemptions from sales and property taxes), I do not address these benefits because they raise differing constellations of issues.

3. In so doing, I treat the economic benefits bestowed by the exemption as a bundle, though they could in theory be decoupled from each other. These benefits include, in order of decreasing fiscal significance, the ability to issue exempt debt instruments (the nonprofit hospital industry's most important source of capital financing), exemption from federal corporate income tax, and access to tax-deductible gifts.

as a capital subsidy. I contend that this case is more plausible than many might expect, but founders on the shortcomings of hospital earnings as an indicator of capital need. Part III concludes by considering a sharply different, non-utilitarian rationale: the notion that nonprofit hospitals *deserve* tax exemption as recognition for their inherent virtues. After attempting to present this rationale in its best light, I argue that it fails as a justification for per se exemption, although it plausibly supports a scaled-back exemption when tied to hospital donors' contributions of time and money.

Part IV explores the possibility of a reformulated exemption, contingent upon the provision of below-cost medical care or community services. After criticizing the notion that such services can plausibly be regarded as charitable, I contend that a credible case can nevertheless be stated for an exemption constructed along these lines. Indeed, I suggest, this case can be made more effectively than proponents of such an exemption have done thus far. The failure of Congress to provide for universal health insurance in 1994 and the rising number of uninsured Americans lends urgency to this case. Even so, I argue, the case for a contingent exemption is deeply problematic on the grounds of efficiency, equity, and morality.

Part V derives some conclusions from the exemption's persistence in the face of our inability to either explain or justify it in functionalist terms. I also offer recommendations about the exemption's future, with respect to hospital services and to risk bearing performed by vertically integrated health care networks. These recommendations reflect an attempt to come to terms with both the absence of a persuasive functionalist justification for the exemption and the patterns of economic and social reliance that its persistence has engendered. I urge an approach that takes into account the costs entailed by the disruption of these patterns, and one that operates to forestall the development of new, socially undesirable patterns of reliance. Finally, and more generally, I suggest that closer attention to such patterns of reliance would deepen our insight into myriad legal arrangements that, like the federal tax exemption of hospitals, defy scholarly efforts to infer purpose.

I. THE ILL-CONCEIVED DECISION TO EXEMPT NONPROFIT HOSPITALS PER SE

A. A New Question of Statutory Interpretation

The proper scope of the charitable exemption from federal taxation has been a matter of dispute since the origins of the income tax. The exemption's drafters did not anticipate modern nonprofit hospitals, which largely serve paying patients, and whether they ought to qualify for the exemption. The currently prevailing understanding of the exemption holds that the terms of the exemption were taken from the common law that excepted charitable trusts from limits imposed on trusts in general.[4] "Charitable" in this sense encompassed a broad range of activities "beneficial to the community," including "the promotion of health."[5] In 1894, when Congress enacted its first charitable ex-

4. *E.g.*, Gen. Couns. Mem. 39,862 (Nov. 21, 1991) *reprinted in* IRS Pos. (CCH) ¶ 2327 (Dec. 6, 1991) (explaining how a charitable organization is viewed under the common law); Bob Jones Univ. v. United States, 461 U.S. 574, 588 (1983); Eastern Ky. Welfare Rights Org. v. Simon, 506 F.2d 1278, 1287 (D.C. Cir. 1974), *rev'd on other grounds*, 426 U.S. 26 (1976). The legislative history of the charitable exemption is indeterminate as to its scope, and disputes persist over whether the exemption should be limited to "relief of poverty" or made more broadly available to activities of "public benefit," even if they do not entail almsgiving. James B. Simpson & Sarah D. Strum, *How Good a Samaritan?: Federal Income Tax Exemption for Charitable Hospitals Reconsidered*, 14 U. Puget Sound L. Rev. 633, 639-41 & n.35 (1991). Prior to 1959, the IRS construed the statutory criterion of "charitable purpose" to require a commitment to relief of the poor. I.T. 1800, 11-2 C.B. 152, 153 (1923). The agency's justification was purely formalistic: the statute's enumeration of multiple exempt purposes (such as "scientific" and "educational") precluded reading the word "charitable" to incorporate other exempt purposes not specifically included. *Cf.* William N. Eskridge & Philip P. Frickey, Cases and Materials on Legislation: Statutes and the Creation of Public Policy 641-42 (1988) (criticizing premises underlying the interpretive maxim of *inclusio unis est exclusio alterius* or "inclusion of one thing indicates exclusion of the other").

When, in 1959, the IRS discarded the relief of poverty requirement in favor of a broad public benefit standard imported from the common law of charitable trusts, the agency simply switched from one unrevealing maxim to another: statutory terms drawn from the common law should be construed in accordance with their common law meaning. Treas. Reg. § 1.501(c)(3)1(d)(2) (1959). Considered together, without other interpretive rationale, these canons of statutory construction are contradictory and indeterminate. *See generally* Karl N. Llewellyn, *Remarks on the Theory of Appellate Decision and the Rules or Canons About How Statutes Are To Be Construed*, 3 Vand. L. Rev. 395, 401-06 (1950) (characterizing classic canons of statutory construction as a shell game where conflicting canons provide the interpreter with diplomatic language for maneuvering toward an outcome preferred on exogenous grounds).

5. Restatement (Second) of Trusts § 358 (1959) (describing the creation of charitable trusts by will); 4 Austin W. Scott, The Law of Trusts 2853 (3rd ed. 1967) (discussing which purposes are considered charitable).

emption from federal tax,[6] nonprofit entities (chiefly hospitals) organized for "the promotion of health" operated primarily on behalf of the poor.[7] The transformation of the hospital into a locus for the treatment of paying patients had not yet occurred, and there was no evidence that the charitable exemption's legislative creators had anticipated such a change.[8] Hence, even if the charitable exemption did incorporate the common law of charitable trusts, it cannot plausibly represent a decision made by its drafters to exempt nonprofit hospitals that function essentially as commercial enterprises.[9]

The rise of such enterprises in the 20th century thereby posed a new question of statutory interpretation: whether the "promotion of health," divorced from any relief for the poor, still merited a charitable exemption. Initially, the IRS and the courts responded with a pragmatic compromise, permitting hospitals that served paying patients to retain their charitable exemptions so long as they provided a substantial amount of free or below-cost care to the poor.[10] The IRS adhered to this compromise through the first half of the century.[11] In the late

6. Tariff Act of 1894, ch. 349, § 32, 28 Stat. 556 (1894) (exempting organizations "organized and conducted solely for charitable, religious, or educational purposes" from corporate income tax). The same basic formulation was repeated in subsequent income tax enactments. *See* Simpson & Strum, *supra* note 4, at 639 nn.29-30 (providing a list of subsequent income tax enactments).

7. ROSEMARY STEVENS, IN SICKNESS AND IN WEALTH 17 (1989) (stating that late 19th century nonprofit hospitals functioned largely as homes for the care of the sick poor).

8. *See* Kenneth Liles & Cynthia Blum, *Development of the Federal Tax Treatment of Charities*, 39 LAW & CONTEMP. PROBS. 6 (1975) (presenting a historical account of the charitable exemption's evolution); *cf.* Boris I. Bittker & George K. Rahdert, *The Exemption of Nonprofit Organizations from Federal Income Taxation*, 85 YALE L.J. 299, 302 (1976) (elaborating on congressional failure to develop a rationale for the charitable exemption).

9. *See* Henry B. Hansmann, *The Role of Nonprofit Enterprise*, 89 YALE L.J. 835, 862-68 (1980) [hereinafter Hansmann, *Nonprofit Enterprise*] (classifying hospitals, nursing homes, and other nonprofit firms that generate revenues almost exclusively through the sale of goods or services as "commercial" nonprofits).

10. *E.g.*, Davis Hosp., Inc. v. Commissioner, 4 T.C.M. (CCH) 312 (1945) (holding that hospital's provision of free care to 30-40% of its patients qualified it for charitable exemption).

11. The interpretation was codified in Revenue Ruling 56-185 which stated that a qualifying hospital must operate "to the extent of its financial ability for those not able to pay." Rev. Rul. 56-185, 1956 C.B. 203. This ruling forbade qualifying hospitals from refusing to accept patients because of their inability to pay, but it promised that even hospitals with "relatively low" charity-care levels could meet the "financial ability" standard. In practice, hospitals that provided free care to fewer than five percent of their patients risked losing their exemptions under the "financial ability" standard, while facilities that gave free

1960s, however, the agency encountered growing pressure from the nonprofit hospital industry to abandon the charity care requirement entirely.[12] By then, many nonprofit hospitals had been providing only minimal free and below-cost care. The industry argued that the introduction of Medicare and Medicaid (in 1965) would soon precipitate a national health insurance program, making charity care an anachronism.[13] The industry's advocates presumed that this argument supported a reconceived exemption, based on "promotion of health" grounds alone. They failed to acknowledge the possibility of their argument supporting the conclusion that the exemption itself was an anachronism.

These political circumstances[14] confronted the IRS with the need to decide clearly whether the "promotion of health" by itself (unaccompanied by assistance for the poor) constituted a "charitable purpose." Presented with a question of statutory construction not considered by the exemption's drafters, the agency could have pursued numerous plausible, interpretive strategies. The IRS could have taken a fiscally cautious tack by declining to read the exemption statute to confer a benefit from the federal treasury without express textual evidence that the statute's drafters had anticipated and resolved this issue.[15] This ap-

---

care to six percent or more of their patients easily qualified. T. J. Sullivan & V. Moore, *A Critical Look at Recent Developments in Tax-Exempt Hospitals*, 23 J. HEALTH & HOSP. L. 65, 67 (1990).

12. *Hearings on Tax Reform, 1969, Part IV, Before the House Comm. on Ways and Means*, 91st Cong., 1st Sess. 1425, 1433 (1969) (statement by American Hospital Association representative advocating exemption for any hospital "so long as its earnings do not inure to the benefit of any private individual—without regard to any test measuring the amount of free patient care").

13. *Id.* at 1427 (discussing government and nonprofit hospital "partnership" in providing care to the poor).

14. The industry also tried to persuade Congress to abolish the charity-care requirement by statute. This effort culminated in a 1969 House vote to eliminate the requirement, but concern in the Senate Finance Committee about marginal income and Medicaid-ineligible families' access to care led to the legislation's demise. Daniel M. Fox & Daniel C. Schaffer, *Tax Administration as Health Policy: Hospitals, the Internal Revenue Service, and the Courts*, 16 J. HEALTH POL. POL'Y & L. 251, 264-65 (1991) (discussing concerns of the Senate Finance Committee regarding marginal income families).

15. *E.g.*, United States v. Wells Fargo Bank, 485 U.S. 351, 357 (1988) (finding that if Congress wanted to create a broad tax exemption it would have created it "notoriously"); *see also* CASS R. SUNSTEIN, AFTER THE RIGHTS REVOLUTION: RECONCEIVING THE REGULATORY STATE 169 (1990) (courts should protect the Treasury by declining to infer tax exemption in the absence of statutory language expressly creating it, reflecting the textualist principle that Congress carefully monitors the revenue process and is in good position to create exemptions when it wants to allow them). This approach would have com-

proach would have led the agency to deny exemption to hospitals which did not provide substantial free and below-cost care.

Alternatively, the IRS could have sought (or at least purported to seek) to reconstruct the basic premises of the exemption's drafters, striving to divine how they "would have wanted it applied to situations they did not foresee."[16] This classic interpretive method, conservative in connotation but indeterminate in practice,[17] would have directed the agency's attention to the "values and attitudes"[18] of the turn-of-the-century legislators who crafted the charitable exemption[19] and to whom the concept of a nonprofit hospital not primarily devoted to the poor was unknown. How these legislators would have reacted to the rise of the commercial nonprofit hospital and the divergence of "promotion of health" from "relief of the poor" would have been the central, perhaps unanswerable, question.

---

ported with the more generally conservative, textualist principle that courts should refrain from "gap-filling" when a statute's drafters have not expressly planned for the particular case at issue; courts adhering to this principle should decide such cases as though the statute were not present. *See* Frank H. Easterbrook, *Statutes' Domains*, 50 U. CHI. L. REV. 533, 544 (1983) ("domain of [a] statute should be restricted to cases anticipated by its framers and expressly resolved in the legislative process"). *Cf.* Joseph Isenbergh, *Musings on Form and Substance in Taxation*, 49 U. CHI. L. REV. 859, 863-64 (1982) (reviewing BORIS I. BITTKER, FEDERAL TAXATION OF INCOME, ESTATES AND GIFTS (1981), contending that courts exercise particular scrutiny of transactions with results unfavorable to the Treasury).

16. RICHARD A. POSNER, THE FEDERAL COURTS: CRISIS AND REFORM 286-87 (1985) (advocating interpretation of statutes via "imaginative reconstruction" of enacting legislators' "essential premises").

17. Indeterminacy arises in part from this method's ambiguous stance toward change in social and legal norms. The method leaves interpreters free to characterize such changes as pertinent to statutory construction (by representing these changes as circumstances that enacting legislators "did not foresee") or as insignificant (by representing such changes as irrelevant to the circumstances not foreseen).

18. POSNER, *supra* note 16, at 287.

19. Another source of indeterminacy arises from the fact that the charitable exemption was repeatedly reenacted, albeit with minimal textual change, as part of successive tax reform packages through the 20th century. *See* Simpson & Strum, *supra* note 4, at 639 & nn.29-30 (detailing successive tax reform packages). This raises the question of *which* enacting legislators' basic premises ought to be the subject of interpretive attention. Interpretive focus on the Congress that most recently reenacted the exemption could lead to the conclusion that the transformation of nonprofit hospitals into enterprises that mainly served paying patients was well-understood. On the other hand, the paucity of legislative history surrounding the successive reenactments suggests that they occurred without reassessment of the meaning of "charity" in general or the role of nonprofit hospitals in particular. If so, attention to the premises of the legislators who originally enacted the charitable exemption would seem most appropriate.

More plausibly, the IRS could have envisioned its interpretive task as a quest for the charitable exemption's rational public purpose in the late 1960s, a search not imprisoned by the time-bound preferences of enacting legislators.[20] This approach would have liberated the agency to respond to textual ambiguity by formulating a policy that served some defensible conception of contemporary public purpose. Interpretive inquiry along these lines might have sought to identify and balance the public values served and sacrificed[21] by the options the IRS faced: maintaining the charity care obligation in some form, abandoning it, or eliminating the charitable exemption altogether for commercial nonprofit hospitals.

B. THE IRS'S IMPLAUSIBLE ANSWER

The IRS followed none of these approaches. In issuing the portentous 1969 revenue ruling that did away with the charity-care requirement,[22] the agency construed the charitable exemption much more broadly than the statutory text expressly required. The IRS acted without a semblance of an effort to divine how the exemption's framers might have applied it to the critical development they did not anticipate: the evolution of the nonprofit hospital from a place for the sick poor to a center for the care of paying customers. The IRS merely declared that the exemption's original drafters had incorporated the common law of charitable trusts, which, in cases involving hospitals devoted to

20. *See* HENRY M. HART & ALBERT M. SACKS, THE LEGAL PROCESS 1415 (1958) (advocating interpretive presumption, barring unmistakable evidence to the contrary, that statutes were enacted by "reasonable persons pursuing reasonable purposes reasonably"). Hart and Sacks pioneered in elaborating this approach, but Ronald Dworkin's recent version of the idea is more sensitive to the influence of myriad historical contingencies upon the inference of rational purpose. RONALD DWORKIN, LAW'S EMPIRE 313-54 (1986) (broadly discussing legislative intent); *cf.* William N. Eskridge, *Dynamic Statutory Interpretation*, 135 U. PA. L. REV. 1479 (1987) (arguing that the "best" interpretation of a statute evolves with changing social, cultural, and legal context).

21. *See* Cass R. Sunstein, *Interpreting Statutes in the Regulatory State*, 103 HARV. L. REV. 405, 494-96 (1989) (where circumstances have changed greatly since a regulatory statute's enactment, it should be construed in a public-regarding manner, in accordance with the principle that its social benefits should be proportional to its social costs).

22. Rev. Rul. 69-545, 1969-2 C.B. 117 (nonprofit hospital that provides care to all persons in its community who are able to pay, and that operates an emergency room open to all persons, qualifies for charitable exemption on ground of "promotion of health" even if it provides minimal free or below-cost care).

caring for the destitute,[23] held that "promotion of health" was a charitable purpose. This claim begged the question of whether the drafters, for whom hospital-based "promotion of health" was a form of relief for the poor, would have viewed the promotion of health for a fee as a charitable purpose. The IRS offered no basis for inferring that the exemption's drafters would have made this leap.

The IRS also failed to mount a credible search for a currently rational public purpose. The agency based its decision to abandon the charity-care requirement on the implausible conclusion, impressed upon the IRS staff by the hospital industry, that inability to afford medical care was a problem of the past.[24] This conclusion was the unsurprising outgrowth of an agency decision-making process poorly designed to identify and reflectively balance public values, discover relevant information, and achieve coordination and consistency with policies generated elsewhere in government.

The IRS conducted its inquiry into the charity-care requirement out of public view and in response to industry representatives' persistent calls for its abandonment.[25] The agency inquiry that formed the basis for its ruling solicited plentiful ex parte input from nonprofit hospital officials but none from representatives of the poor.[26] While industry advocates hovered closely

23. *See* Simpson & Strum, *supra* note 4, at 642 n.42 (citing 19th century decisions upholding trust instruments that endowed hospitals for "sick and indigent females," "aged, decrepit, and worn-out sailors," and "foundlings").

24. The IRS's announcement of the decision, in Revenue Ruling 69-545, *supra* note 22, made no mention of this conclusion; Revenue Ruling 69-545 purported to rest the decision exclusively upon the doctrinal formalism that the charitable exemption statute, I.R.C. § 501(c)(3), incorporated the common law of charitable trusts. But the IRS officials who developed and issued the ruling later acknowledged having accepted the hospital industry's contention that charity care had become an anachronism. Fox & Schaffer, *supra* note 14, at 252-54, 263 (discussing the basis of IRS policy); *see also* Robert S. Bromberg, *The Charitable Hospital*, 20 CATH. U. L. REV. 237, 257 (1970) (explaining defense of this position by IRS attorney principally responsible for drafting Rev. Rul. 69-545). The Treasury Department took this position in litigation, and a finding that the need for free care had "largely disappeared" was central to the D.C. Circuit Court of Appeals' holding that Revenue Ruling 69-545 was "founded on a permissible definition of the term 'charitable.'" Eastern Ky. Welfare Rights Org. v. Simon, 506 F.2d 1278, 1288-90 (D.C. Cir. 1974), *cert. granted*, 421 U.S. 975 (1975), *and vacated*, 426 U.S. 26 (1976).

25. *See* Fox & Schaffer, *supra* note 14, at 263-71 (discussing IRS response to Congress and judicial action on the issue of charitable exemptions).

26. *Id.* at 271 (discussing the lack of input by the poor in IRS policy decisions and discussing Judge Skelly Wright's argument in *Eastern Ky. Welfare Rights Org.*); *Eastern Ky. Welfare Rights Org.*, 506 F.2d at 1291 (Wright, J., concurring in part and dissenting in part) (explaining that the poor were not

about the process, pressing their concerns, the poor were nowhere to be seen.[27] Furthermore, the IRS failed to coordinate its reassessment of the charity-care requirement with the Department of Health, Education, and Welfare, which bore responsibility for implementing Medicare, Medicaid, and other federal health care programs. The thesis that government programs were turning medical indigency into a relic of the past remained untested via a deliberative process that received input from those most affected or knowledgeable.

A serious inquiry conducted by the IRS into the health needs of the poor would have quickly revealed the tragically incomplete medical safety net woven by government programs.[28] Millions of medically indigent Americans were ineligible for government-funded health care, and forced to rely on the willingness of private hospitals to provide free and below-cost care. The expressed premise behind the 1969 ruling, that Americans' need for free care was vanishing, was pure fantasy.

Moreover, exemption of nonprofit hospitals that serve only paying patients fits poorly with IRS treatment of other nonprofit health care organizations. The agency's determination that the "promotion of health" constitutes a charitable purpose when hospitals are at issue conflicts with the IRS's continuing insistence that other health care enterprises must provide free or below-cost services to qualify for exemption.[29] With respect to nonprofit clinics, pharmacy cooperatives, and other outpatient serv-

---

given notice of IRS's proposed interpretive change, while the IRS, not an expert in health care delivery needs of the poor, denied itself access to important information by failing to follow informal, notice-and-comment rulemaking procedures set forth in Administrative Procedure Act § 553).

27. The process exemplified the paradigm of administrative decision-making in which wealthy, tightly-organized, and regulated interests exercise sustained influence while economically disadvantaged and poorly-organized potential beneficiaries fail to make themselves heard. *See* William N. Eskridge, *Politics Without Romance: Implications of Public Choice Theory for Statutory Interpretation*, 74 VA. L. REV. 275, 290, 317 (1988) (invoking "public choice" theory to model tendency of administrative decision-making to discount concerns of diffuse interests).

28. GEORGE SILVER, A SPY IN THE HOUSE OF MEDICINE 45-56 (1976) (discussing the rise in medical demand); ROSEMARY STEVENS, AMERICAN MEDICINE & PUBLIC INTEREST 496-509 (1971) (examining the federal government's relationship to the health care system); *see also* OTTO KERNER ET AL., REPORT OF THE NATIONAL ADVISORY COMMISSION ON CIVIL DISORDERS 1, 137 (1968) (providing statistical analysis of family expenditures for medical care and percentage of population making medical visits).

29. *E.g.*, Federation Pharmacy Servs. v. Commissioner, 72 T.C. 687, 690 (1979), *aff'd*, 625 F.2d 804 (8th Cir. 1980) (determining that a pharmacy was not tax exempt under the Internal Revenue Code).

ices, the IRS (with judicial acquiescence) has maintained its compromise stance toward hospitals before 1969: to obtain exempt status, an entity must provide a substantial amount of free or below-cost service.[30] Neither the IRS nor acquiescing appellate court judges have proposed a plausible rationale for this patent inconsistency.[31]

II. ALTERNATIVE RATIONALES FOR PER SE EXEMPTION

The IRS's failure to formulate a plausible rationale for the per se exemption of nonprofit hospitals has encouraged efforts by others to construct persuasive accounts. These accounts invoke several influential models of the charitable exemption's general contours. In this section, I consider three such models: exemption as a quid pro quo for nonprofit firms' production of positive externalities, exemption as a subsidy that compensates nonprofits for their inability to raise capital in equity markets, and exemption as recognition for virtue. None of these approaches, however, is convincing as a basis for exempting nonprofit hospitals per se.

A. Positive Externalities and Market Failure

The Treasury Department has in recent years based its defense of the nonprofit hospital sector's per se exemption[32] upon

30. *Id.* In acquiescing to this inconsistency, courts presented with appeals from non-hospital entities have baldly acknowledged it by citing, as authority, pre-1969 decisions (superseded in the hospital context by Rev. Rul. 69-545) imposing charity-care obligations on hospitals. *E.g.*, *Federation Pharmacy Servs.*, 625 F.2d at 807 (citing Sonora Community Hosp. v. Commissioner, 46 T.C. 519 (1966) and Hassett v. Associated Hosp. Serv. Corp., 125 F.2d 611 (1st Cir. 1942), *cert. denied*, 316 U.S. 672 (1942) (holding that hospitals are not tax exempt when requiring a fee as a prerequisite to service)).

31. The only judicially-suggested distinction is a question-begging one: whether the activity at issue is "normally pursued by commercial [for-profit] enterprises." *Federation Pharmacy Servs.*, 625 F.2d at 808. The question begged is why the status of an activity as charitable should depend on the prevalence of the for-profit form, particularly if the nonprofit firms that engage in the activity survive by selling services at or above cost. The fact that nonprofit firms outnumber for-profits in the hospital industry does not by itself demonstrate that hospital care is any less "commercial" than, for example, manufacture of pharmaceuticals, an activity conducted almost exclusively by for-profit firms.

32. During the Bush Administration, the department supported Revenue Ruling 69-545 and opposed legislation that would have conditioned nonprofit hospitals' eligibility for exemption upon their provision of threshold levels of charity care. *Tax-Exempt Status of Hospitals, and Establishment of Charity Care Standards: Hearing before the House Comm. on Ways and Means*, 102d

the oft-repeated assertion that nonprofit hospitals perform better than for-profits as suppliers of services that produce positive externalities. These services include biomedical research, clinical teaching, care for the poor, and an array of health-promoting community programs.[33] They are "not provided or . . . inadequately provided by for-profit hospitals," in the department's view, because "market prices . . . do not reflect the benefit [these services] confer on the community as a whole."[34] Hence, the per se exemption constitutes an indirect form of government provision of these services.[35] Instead of supplying them itself, the federal government subsidizes their provision by the private sector.[36] By channeling this subsidy selectively to nonprofit hospitals, the government ideally achieves maximum leverage because nonprofits are less responsive to market forces and therefore possess a greater tendency than for-profits to produce services with positive externalities.

This rationale superficially resembles Burton Weisbrod's model of voluntaristic, nonprofit enterprise as a response to the market's failure to generate a socially optimal supply of "public goods,"[37] possessing positive externalities from which "free rid-

---

Cong., 1st Sess. 34-37 (1991) [hereinafter Treasury Statement] (statement of Michael J. Graetz, Deputy Assistant Secretary for Tax Policy, U.S. Dep't of the Treasury). In 1991, however, the IRS indicated its intention to apply Revenue Ruling 69-545 in a manner that would require nonprofit hospitals to provide some free and below-cost care. *Id.* at 109-10 (statement of John E. Burke, Assistant Commissioner, Employee Plans and Exempt Organizations, IRS). Acute care general hospitals, the agency said, will be expected to admit Medicaid patients without discrimination. (In most states, Medicaid reimburses hospitals at rates well below actual cost.) Moreover, general hospitals will be obliged to operate emergency rooms to maintain their exemptions. *Id.* Federal "antidumping" legislation requires hospitals with emergency rooms to treat all patients with unstabilized emergency conditions or in active labor, regardless of ability to pay. 42 U.S.C. § 1395dd(c)(1) (1994).

33. Treasury Statement, *supra* note 32, at 41-43 (statement of Michael J. Graetz, Deputy Assistant Secretary for Tax Policy, U.S. Dep't of the Treasury).

34. *Id.* at 41-42.

35. This position is a variant of the rationale most commonly articulated by courts as the justification for charitable exemption: eligible organizations relieve government of the burden of providing some social services (e.g., medical care for the poor), thereby meriting tax exemption as a quid pro quo. *See* Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 345-63 (1991) (reviewing and critiquing the quid pro quo theory as applied to hospitals).

36. The Treasury Department has been silent on the question of whether subsidization of private hospitals via the per se exemption generates greater production of positive externalities than would an equal expenditure in the form of direct government provision of hospital services.

37. Weisbrod's model, which has considerable explanatory power as a portrayal of American voluntarism, postulates that communally-oriented actors

ers" cannot be excluded.[38] However, Weisbrod's model, which interprets the tax exemption of nonprofit firms as a means to

with high demand for such goods attempt to satisfy this demand by making donations to private organizations that produce them. BURTON WEISBROD, THE VOLUNTARY NONPROFIT SECTOR: AN ECONOMIC ANALYSIS 52-61 (1977). In theory, a well-functioning majoritarian political process will lead to government provision of a public good at a socially optimal level if demand for that good is homogeneous. If demand for the good varies among citizens (due to heterogeneous desires and ability to pay for the good), then majoritarian politics will lead to government provision of the good at the median demand level. Government provision of the good at a level higher or lower than median demand will be rejected by a majority of citizens. *Id.* at 52-57.

Government provision at the median demand level will leave above-median demanders unsatisfied. Some of them will turn to the voluntary sector, joining with fellow high-demanders to support additional production. Free-rider problems will leave some above-median demand unsatisfied by such voluntary activity. Free-rider difficulties are reduced, however, by two countervailing influences: social pressures to contribute and government subsidies to voluntary institutions and their supporters. Tax exemption is one such subsidy. BURTON WEISBROD, THE NONPROFIT ECONOMY 25-31 (1988) [hereinafter WEISBROD, THE NONPROFIT ECONOMY]; WEISBROD, THE VOLUNTARY NONPROFIT SECTOR, *supra*, at 51-76 (describing the role of the nonprofit sector in a three-sector economy).

One might object that above-median demanders, if sufficiently wealthy to support voluntary enterprise, could readily translate their wealth into disproportionate influence on the political process and thereby induce government production levels in excess of median demand. The more responsive the political process to activity by well-financed and well-organized minorities, the easier (cheaper) it will be for a group of high demanders to exercise disproportionate influence. The financial leverage available through access to the public fisc would seem to make such an investment in political influence very appealing. This effect is surely felt to some extent; it probably accounts for federal support of myriad commercial, scientific, literary, and artistic endeavors. Actors at the high end of a public good's demand distribution, however, can pursue their preference with greater certainty and control by supporting private, voluntary enterprise.

38. Pure "public goods" are not consumed by use and cannot be supplied to one user without making them available to all. The classic example is a lighthouse warning beacon. Widely-published, easily-accessible research results are another example. Use of public goods by one individual does not diminish the quantity available to others, and non-paying users cannot be excluded except at a prohibitive cost. RICHARD A. MUSGRAVE & PEGGY B. MUSGRAVE, PUBLIC FINANCE IN THEORY AND PRACTICE 49-80 (2d ed. 1976). Some goods are incompletely "public" in this sense. They are consumed in part by use, and nonpayers are excluded from some of their benefits. Incompletely public goods can be described alternatively as *private* goods with *positive externalities*—aspects that are neither consumed by use nor possible to limit to paying customers. Formal education is an example. Much of its benefit for students (e.g., enhanced economic opportunity) does not accrue equally to persons outside schoolroom walls, but some of what students learn may enrich our communal cultural and political life. In the Treasury Department's view, nonprofit hospital services are another example. The Department's rationale for nonprofit hospitals' per se tax exemption is grounded on the belief that their activities produce important positive externalities.

stimulate voluntary contributions,[39] is only minimally relevant to an understanding of nonprofit hospitals. Nonprofit hospitals, as a rule, are not voluntaristic enterprises; they derive virtually all of their revenues from the sale of services to consumers for a price. Voluntaristic contributions account for at most one to two percent of the nonprofit hospital sector's revenues.[40]

The Treasury Department's argument does not rest on an outmoded portrayal of nonprofit hospitals as voluntaristic institutions. Rather, it posits that even in the face of market pressures, nonprofit hospital managers are more inclined than their for-profit counterparts to provide services with "public good" characteristics.[41] All else being equal, the Department views nonprofit hospitals as producing more of such services than for-profits.[42] As a corollary to this argument, government subsidi-

39. Government subsidies, including tax exemptions, counterbalance the free rider problem's dampening effect upon potential donors' willingness to contribute. *See supra* note 37 and accompanying text (noting the reduction in free-rider difficulties).

40. GERALD F. ANDERSON ET AL., PROVIDING HOSPITAL SERVICES: THE CHANGING FINANCIAL ENVIRONMENT 47-48 (1989) (reporting that "philanthropy represented less than 1.3 percent of funds used for hospital care" in 1985). Invoking the Weisbrod model, Hall and Colombo have proposed that the all-or-none approach represented by the per se exemption be replaced by a more flexible exemption, available selectively to activities within a hospital that receive high levels of donative support. Hall & Colombo, *supra* note 35, at 405-10.

41. The literature lends some support to this claim. *See* DENNIS R. YOUNG, IF NOT FOR PROFIT, FOR WHAT? 16-17 (1983) (arguing that nonprofits attract managers with less profit-oriented and more community-minded values than managers attracted by for-profits). *See also* WEISBROD, THE NONPROFIT ECONOMY, *supra* note 37, at 31-33 (discussing the phenomenon of managerial sorting, which prompts managers to gravitate toward those types of organizations most compatible with their values and personal preferences). Two studies of managerial career choice have found differences in personality, values, and behavior between students planning careers in nonprofit and for-profit organizations. Those opting for nonprofits put a premium on being cheerful, forgiving, and helpful, whereas their for-profit counterparts attached more importance to financial prosperity, ambition, neatness, obedience, and dependability. James R. Rawls et al., *A Comparison of Managers Entering or Reentering the Profit and Nonprofit Sectors*, 18 ACAD. MGMT. J. 616, 618-20 (1975).

42. Nonprofit hospital advocates assert that there are several reasons why this form is more likely to produce services with "public good" characteristics. David Seay and Bruce Vladeck offer a number of overlapping arguments to this effect. They contend that since most boards of trustees are comprised of members of the local community, nonprofit hospitals are responsive to the needs of the community. Thus, the values of the community permeate the hospital. This tie, so the theory goes, makes it more likely that the hospital will have a long-term commitment to the community and will not relocate at the first sign of financial trouble. Furthermore, Seay and Vladeck contend, without the requirement of maximizing profits, the trustees can manage the trust in a way consistent with the charitable intentions of the donors. J. David Seay & Bruce

zation at a given level will generate a larger increment of public goods production if directed to a nonprofit facility than to an otherwise equivalent for-profit. These propositions presume some willingness on the part of health care payers to absorb additional costs incurred by hospitals to produce public goods. Moreover, the Department's reliance upon these propositions to justify the per se exemption presumes that a given government expenditure will generate more public goods if channeled to nonprofit hospitals via the exemption than if used to finance government provision or purchase of these goods.

These propositions are highly suspect. To begin with, the Department's assertion that nonprofit hospitals as a rule produce more biomedical research, teaching, care for the poor, and community services than do for-profits poorly characterizes the relevant data. A comprehensive assessment of the abundant evidence bearing on the comparative performance of nonprofit and for-profit hospitals is beyond the scope of this article.[43] A brief review, however, shows that this evidence does not support the Treasury Department's generalization.

The generalization's basic flaw flows from the fact that nonprofit hospitals display remarkable heterogeneity in their production of biomedical research, education, indigent care, and community service. This heterogeneity is greatest for research, a classic public good. In proportion to its market share, the non-

---

C. Vladeck, *Mission Matters*, *in* IN SICKNESS AND IN HEALTH 1, 13-18 (J. David Seay & Bruce C. Vladeck eds., 1988) (written by two senior executives of a foundation sponsored by nonprofit hospitals in New York City).

Proof that nonprofit hospitals behave in a less commercial manner than their for-profit counterparts and thereby produce public goods at higher levels would not suffice to rationalize the per se exemption of nonprofits. *Cf.* Hall & Colombo, *supra* note 35, at 373 (noting that "why nonprofits exist is a fundamentally different question than whether they should be exempt"). A justification based on the public goods model would require the establishment of a causal link between per se exemption and the nonprofits' greater production of public goods. Without such a link, the exemption would merely represent an after-the-fact payment for behavior that would have occurred anyway, as a product of the pursuit of private preferences. Were such a link to be established, it would raise the question of whether provision of an equivalent subsidy to for-profit hospitals would prompt them to produce public goods at higher levels. An affirmative answer would undermine the public goods rationale for the current per se exemption unless it could be shown that subsidizing for-profits to an equal extent would induce less production of public goods than does the exemption.

43. *See* BRADFORD H. GRAY, THE PROFIT MOTIVE AND PATIENT CARE: THE CHANGING ACCOUNTABILITY OF DOCTORS AND HOSPITALS 90-110 (1991) (conducting a thorough review of empirical studies on the differences between performances of nonprofit and for-profit health care institutions).

profit hospital sector does perform more research than the for-profit sector.[44] However, a small number of elite teaching hospitals staffed by medical school faculty conduct the vast majority of this research.[45] The more typical nonprofit hospital, a community facility staffed by local medical practitioners, performs little or no biomedical research.[46] Thus, the nonprofit form does not appear per se to engender the production of more research than the for-profit form.

The distribution of medical education, less plainly a public good,[47] poses the same problem for the Treasury Department's generalization. The nonprofit sector provides disproportionately more medical training than do for-profit hospitals as a group. But medical training, like research, is concentrated in elite, university-affiliated teaching hospitals. The typical community hospital, whether nonprofit or for-profit, does not function as a major training center, although some educational activities[48] are spread more widely among community hospitals than is medical research. Thus, nonprofit status in itself has not been shown to induce the provision of more medical education than for-profit status.

The comparative performance of the nonprofit and for-profit sectors in providing free and below-cost care to the poor (an activity with some public good attributes)[49] is a bitterly disputed

44. *See* M. Gregg Bloche, *Corporate Takeover of Teaching Hospitals*, 65 S. CAL. L. REV. 1035, 1043 (1992) [hereinafter Bloche, *Corporate Takeover of Teaching Hospitals*].

45. *Id.* at 1076-78, 1117.

46. The average nonprofit community hospital is similar in this regard to the typical for-profit hospital in that neither conducts much research. Only a small minority of for-profit hospitals, either affiliated with medical schools or otherwise designated by investor-owned hospital chains as major tertiary care centers, generate considerable research. *Id.* at 1040.

47. Exclusion of nonpayers from medical training poses little difficulty. Moreover, medical education is "consumed" by those who receive it, especially when training takes the form of small-group experiences of clinical apprenticeship. On the other hand, the diffusion of medical knowledge through society via medical education may produce positive externalities in the form of social benefits (e.g., the spread of knowledge about healthy eating or living) not consumed by use, and from which exclusion of nonpayers is difficult.

48. Examples include nursing schools and residency training for new medical school graduates. In 1989, the American Hospital Association (AHA), the principle trade association representing nonprofit hospitals, had 6720 member hospitals. Of these, 1235 (18%) had residency training programs and 157 (2%) had professional nursing schools. AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS: A COMPREHENSIVE SUMMARY OF U.S. HOSPITALS 202 (1990).

49. Bloche, *Corporate Takeover of Teaching Hospitals*, *supra* note 44, at 1090-91 (noting that although clinical benefit to indigent patients who receive care is a private good, gratification derived by society from the knowledge that

subject.[50] As a group, nonprofit hospitals appear to provide more uncompensated care, measured in proportion to their operating expenses, than do for-profit facilities.[51] The distribution of uncompensated care, however, like that of research and education, is highly uneven. Uncompensated care performed by the private sector is concentrated in major urban teaching hospitals,[52] almost all of which are nonprofits. By contrast, many community hospitals, nonprofit and for-profit alike, provide minimal amounts of free and below-cost care. Indeed, the nonprofit hospitals that benefit most from the tax exemption, those with

---

needy persons are obtaining medical care is a public good or positive externality). More tangible benefits accruing to society from improving the health of poor people, such as enhanced economic productivity, can also be characterized as public good attributes or positive externalities.

50. GRAY, *supra* note 43, at 90-110 (comparing the performance of for-profit and nonprofit health care organizations).

51. *See* LEWIN & ASSOCIATES, SETTING THE RECORD STRAIGHT: THE PROVISION OF UNCOMPENSATED CARE BY NOT-FOR-PROFIT HOSPITALS § 3.1 (1988) (study commissioned by the AHA). This study's comparisons of nonprofit and for-profit hospitals' aggregate shares of statewide uncompensated-care burdens in five states showed that in each state, as a proportion of operating expenses, the nonprofits provided more uncompensated care than did the for-profits.

National comparisons of uncompensated care provided by the nonprofit and for-profit sectors indicate that they bear approximately equivalent shares of this burden. *See, e.g.*, GENERAL ACCOUNTING OFFICE, NONPROFIT HOSPITALS: BETTER STANDARDS NEEDED FOR TAX EXEMPTION 12 (May 1990) [hereinafter GAO Report] (report to the Chairman, U.S. House of Representatives Select Committee on Aging) (according to data from the AHA's Annual Survey of Hospitals, American nonprofit hospitals provided uncompensated care valued at 4.8% of total revenue in 1988 while for-profit hospitals provided uncompensated care worth 5.2% of their revenue).

As the Lewin & Associates study notes, however, national comparisons can be misleading. For-profit hospitals are concentrated in southern and western states with stricter-than-average Medicaid eligibility requirements and poorer Medicaid coverage (except in the case of California), greater proportions of uninsured patients, and lesser availability of public hospitals. The need for uncompensated care is thus higher in states where for-profits have a strong presence. Citing data from several such states (Florida, North Carolina, Tennessee, and Virginia) which indicate a contrast between for-profit uncompensated-care burdens close to the national average and nonprofit burdens that are 50 to 100% higher, Lewin & Associates note that national averages obscure these differences by incorporating the generally lower uncompensated-care loads borne by nonprofits in other states (where for-profits are less common). LEWIN & ASSOCIATES, *supra*, § 2.9. Any systematic tendency of nonprofit hospitals to deliver more free and below-cost care than for-profits provide would be masked in national figures by this statistical effect.

52. *E.g.*, GAO Report, *supra* note 51, at 21-23 (noting that nine teaching hospitals in New York City, with 16% of New York State's hospital beds, accounted for 38% of the uncompensated care provided statewide by nonprofit hospitals in 1987).

the highest percentage levels of operating income,[53] tend to provide the lowest rates of uncompensated care.[54] Studies of comparable nonprofit and for-profit hospitals, matched on the basis of community demographics and patient characteristics, have not shown a significant difference in rates of uncompensated care.[55] Thus, the proposition that the nonprofit form itself generates more free and below-cost care than the for-profit form is inconsistent with the available data.

In short, the Treasury Department's reliance on the proposition that nonprofit hospitals produce public goods at higher levels than do for-profits appears misplaced. Likewise, the Department's professed belief that a given government subsidy will generate more public goods production if directed to the nonprofit sector than to for-profits is not well-supported. If the nonprofit form per se does not induce hospitals to commit a higher proportion of their resources to the provision of public goods than do for-profits, then it is unlikely that nonprofits per se will be more inclined than for-profits to apply the benefits of tax exemption (or any other unrestricted subsidy) toward the production of public goods.

Nor is it clear that the per se exemption generates more of these public goods than would an equal federal expenditure to provide or purchase these goods more directly. On the contrary, the poor match between the exemption's value to individual hospitals and their levels of research, teaching, and free care suggests that government could generate more of these activities at

53. These hospitals receive a double benefit from the exemption. They pay no income tax, and their incomes enhance their credit-worthiness and thus their ability to take advantage of tax-exempt debt financing.

54. GAO Report, *supra* note 51, at 25-26, 50 (showing that low-uncompensated care hospitals had higher profit margins than high-uncompensated care hospitals in California (1986), Florida (1985), Iowa (1987), Michigan (1987), and New York (1987)).

55. Frank A. Sloan et al., *Identifying the Issues: A Statistical Profile, in* UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 16, 21-22 (Frank A. Sloan et al. eds., 1986); Robert V. Pattison & Hallie M. Katz, *Investor-Owned and Not-For-Profit Hospitals: A Comparison Based on California Data*, 309 NEW ENG. J. MED. 347, 350-51 (1983); Frank A. Sloan & Robert A. Vraciu, *Investor-Owned and Not-For-Profit Hospitals: Addressing Some Issues*, 2 HEALTH AFF. 25, 34 (1983). Lewin & Associates criticize such studies for eliminating "some of the very factors," including hospital "size, teaching status, and location," that "distinguish" nonprofit and investor-owned hospitals. LEWIN & ASSOCIATES, *supra* note 51, §§ 2.14, 2.2. Controlling for these factors is essential to any empirical effort to determine whether the nonprofit form per se engenders the provision of uncompensated care at higher levels.

the same cost by directly providing or paying for them.[56] In particular, evidence that many tax-exempt hospitals provide no more indigent care than do similarly situated for-profit hospitals[57] invites the inference that per se exemption is enormously wasteful, measured by its capacity to induce production of public goods. As a subsidy for the private provision of medical research, education, and care for the poor, the per se exemption thus seems much less desirable than direct government provision or payment for these services.

B. Constraints on Capital Formation

Henry Hansmann has proposed that the income tax exemption of nonprofit firms be understood as a crudely-targeted but easily-administered capital subsidy.[58] Hansmann disclaims the applicability of his explanation to the hospital industry, which he contends has no need for such a subsidy.[59] But a case can be made on behalf of this explanation's relevance for hospitals, in part because of changes that have occurred in the organization of American medicine since Hansmann proposed it.

---

56. Government can either perform such services directly or subsidize their provision by private actors. The latter might be done through contracts, grants, or tax credits or deductions made contingent on provision of the desired services.

In limited circumstances, government subsidization of nonprofit firms may be a cheaper way to produce services with a public good aspect than direct provision of such services by government. For example, Estelle James has argued that constraints on the government's ability to employ factors of production at market prices can make it more expensive for the government to produce such goods itself than to subsidize their production by nonprofit firms. Estelle James, *The Nonprofit Sector in Comparative Perspective*, *in* THE NONPROFIT SECTOR: A RESEARCH HANDBOOK 397, 410-12 (Walter W. Powell ed., 1987).

It seems doubtful, however, that James' argument can explain the per se exemption of nonprofit hospitals, given the absence of evidence that the exemption generates public goods production at a level even close to the exemption's value. Moreover, available evidence suggests that the costs of government-run hospitals are lower than those costs at private facilities. *See* AMERICAN HOSPITAL ASSOCIATION, *supra* note 48, at 7 (stating that in 1989 the average cost per inpatient-day for state and local government-owned community hospitals was $582.15, compared to $642.45 for nonprofits and $707.90 for for-profits). On the other hand, the quality of care at government hospitals may be lower than at private facilities.

57. *See supra* note 51 and accompanying text.

58. Henry Hansmann, *The Rationale for Exempting Nonprofit Organizations from Corporate Income Taxation*, 91 YALE L.J. 54, 72 (1981) [hereinafter Hansmann, *Rationale*].

59. *Id.* at 89.

1. Hansmann's Capital Subsidy Model

Hansmann's rationale for the exemption builds on the premise that nonprofit producers operate more efficiently than for-profits when purchasers of goods or services lack the information they need to monitor the output of producers. When purchasers are well-informed about the output of competing producers, classical economics holds that for-profit firms, driven by the imperative to generate income for their owners, will perform more efficiently than their nonprofit competitors.[60] When purchasers are poorly informed about the quality or volume of producers' outputs, however, for-profit firms are driven by their income-seeking imperative to exploit purchasers, either by overcharging or by making unobservable reductions in the quality or quantity of outputs.[61] By contrast, nonprofit firms' inability to distribute revenues that exceed expenses (what Hansmann terms the "non-distribution constraint") reduces the propensity of nonprofits to exploit poorly-informed purchasers.[62] Hence, when purchasers lack sufficient information to impose ef-

60. ESTELLE JAMES & SUSAN ROSE-ACKERMAN, THE NONPROFIT ENTERPRISE IN MARKET ECONOMICS 20-21 (1986).

61. This information gap and the consequent possibility of cheating by producers creates the condition Hansmann terms "contract failure," a situation in which potential purchasers fail to strike Pareto-desirable deals with producers because the purchasers fear that their ignorance will be exploited. Hansmann, *Nonprofit Enterprise*, *supra* note 9, at 837-45. David Easley and Maureen O'Hara have developed a closely-related model: where purchasers are unable to monitor output or managerial effort, the managers and owners of for-profit producers will tend to cheat for personal gain. Hence, potential purchasers refuse to contract with these producers. By contrast, according to Easley and O'Hara, nonprofit producers require their managers to make a minimum observable effort for a fixed rate of pay, insuring that the rest of the contract price is put to productive use on purchasers' behalf. Under these conditions potential purchasers are willing to contract. David Easley & Maureen O'Hara, *Optimal Nonprofit Firms*, *in* THE ECONOMICS OF NONPROFIT INSTITUTIONS: STUDIES IN STRUCTURE AND POLICY 85 (Susan Rose-Ackerman ed., 1986) (explaining a potential purchaser's inclination to contract with a nonprofit hospital); David Easley & Maureen O'Hara, *The Economic Role of the Nonprofit Firm*, 14 BELL J. ECON. 531, 536-38 (1983) (explaining the relative merits of contracting with a nonprofit firm).

62. Potential purchasers, Hansmann writes, are poorly informed, and therefore vulnerable to exploitation, if they:

> have difficulty in (1) comparing the quality of performance offered by competing providers before a purchase is made, or (2) determining, after a purchase is made, whether the service was actually performed as promised. As a result of such conditions, ordinary market competition may be insufficient to police the performance of for-profit firms, thus leaving them free to charge excessive prices for inferior service. In such circumstances consumers often turn to nonprofit providers, which, owing to the nondistribution constraint, have less opportunity

fective market discipline on producers, the nonprofit form may be more efficient than the for-profit organization.[63] The non-distribution constraint's efficiency advantage in such circumstances derives both from producers' diminished propensity to exploit and purchasers' enhanced sense of trust.[64]

The non-distribution constraint, however, carries a large disadvantage. Nonprofit organizations are not able to distribute profits to contributors of capital, diminishing their ability to raise capital,[65] and thus to grow.[66] This reduces a nonprofit firm's ability to achieve its efficiency-enhancing potential when purchasers have poor information about producers' outputs. Hansmann justifies the per se income tax exemption of nonprofit firms as a sensible way to compensate for this handicap.[67] He argues that it is rational for government to subsidize capital formation by a nonprofit firm if the subsidy's cost is less than the efficiency gain it induces.[68] To be rational in this sense, a capital subsidy should be linked to nonprofit firms' potential for efficiency-enhancing growth—e.g., the government should subsidize only growth that adds to social welfare. In a crude

---

and incentive to exploit consumers than do for-profit firms, and thus serve as fiduciaries of a sort for their consumers.

Hansmann, *Rationale*, *supra* note 58, at 69.

63. Strictly speaking, the nonprofit form is more efficient than the for-profit form when the efficiency gain resulting from the non-distribution constraint's reduction of exploitative incentives is greater than the efficiency loss resulting from the non-distribution constraint's adverse effect on productivity incentives. By dampening a firm's impetus to pursue profits, the non-distribution constraint facilitates productivity-reducing exploitative behavior by managers and staff, such as inefficiency or organizational slack.

64. Hansmann, *Nonprofit Enterprise*, *supra* note 9, at 847. Hansmann appears ambivalent about which of these two effects is most important and about how much weight, in the calculus of efficiency, should be accorded to trusting feelings alone, apart from economic behaviors that may or may not merit trust. *Id.*

65. The non-distribution constraint prevents nonprofit firms from raising capital by selling equity shares to investors. Thus, nonprofit firms must rely on debt, donations, and retained earnings (past and present net income) to meet their capital needs.

66. Theorists frequently posit this handicap as an explanation for the proprietary hospital sector's large market shares in regions that exhibit fast-growing economies, expanding populations, and a rapidly-increasing demand for hospital care. *E.g.*, Bruce Steinwald & Duncan Neuhauser, *The Role of the Proprietary Hospital*, 35 LAW & CONTEMP. PROBS. 817, 835-38 (1970) (setting forth the first published statement of this theory).

67. Hansmann, *Rationale*, *supra* note 58, at 74.

68. *Id.* This efficiency gain, Hansmann's model holds, results from the substitution of nonprofit for for-profit production as nonprofits take advantage of capital subsidies to grow and displace for-profits in industries characterized by purchaser ignorance about outputs. *Id.*

way, Hansmann contends, the income tax exemption meets this test.[69]

Hansmann notes that the exemption's value to a firm in a given year depends on the firm's earnings.[70] The firm's earnings, he argues, are "likely to be proportional" to the extent demand for the firm's output exceeds the firm's supply capacity,[71] since excess demand empowers the firm to set prices at greater-than-equilibrium levels.[72] Excess demand, Hansmann assumes, signals that growth (and new capital investment) is socially desirable as long as nonprofit organizations in the firm's industry possess the aforementioned efficiency advantages.[73] Therefore, a nonprofit firm's earnings are a good measure of its need for a capital subsidy, making income tax exemption a sensible way to provide such a subsidy.[74]

---

69. *Id.*

70. *Id.* at 71. The exemption yields a direct subsidy only when a firm generates positive earnings, and would therefore owe income taxes absent the exemption. The exemption's value to a firm in a given year, however, is only roughly proportional to the firm's earnings. This is so because the exemption's indirect benefits, access to tax-deductible donations and ability to sell tax-exempt debt instruments, are not likely to accrue to a firm in exact proportion to its net earnings.

71. *Id.* at 74. Hansmann's attribution of nonprofit firms' earnings exclusively to excess demand presumes that nonprofits do not exploit purchasers' ignorance about outputs by charging excessive prices or skimping on quality. The non-distribution constraint, Hansmann appears to assume, takes away a firm's incentives to engage in such exploitation. The validity of this assumption is doubtful. The importance of retained earnings as a source of capital gives nonprofit managers powerful reason to take advantage of opportunities to increase their organization's income. Nonprofit managers seek income to pursue myriad goals, altruistic and selfish, that are not barred by the non-distribution constraint. *See* YOUNG, *supra* note 41, at 15-16 (noting that nonprofit actors sometimes manipulate their status toward selfish ends). Exploitation of purchasers in service of these goals is to be expected, especially in industries characterized by purchaser ignorance about outputs. Thus, nonprofit earnings are least likely to stem exclusively from excess demand in those industries in which Hansmann expects nonprofits to perform more efficiently than for-profits.

72. *Id.* at 77. At competitive equilibrium in a perfect market, a nonprofit firm's prices would yield zero earnings. The firm's revenues would exactly cover the costs of labor, supplies, interest on debt, and depreciation.

73. *Id.* at 74-75.

74. Under excess demand conditions, Hansmann's model predicts that, all else being equal, income taxation of nonprofits would reduce the rate at which a firm could grow toward equilibrium as well as the firm's equilibrium output level. *Id.* at 79. He predicts reduced growth because taxation shrinks the pool of accumulated earnings available to finance expansion, and reduced output levels because managers blessed with excess demand have the option of using income from the sale of output, produced at costs less than the market price, to pay for the production of additional output at marginal costs greater than the market price. In the extremes, a firm can either sacrifice all potential profits in

Relying on this rationale, Hansmann would make the exemption available to those nonprofits that are, owing to purchasers' inability to evaluate output, likely to be more efficient than for-profits in the same industry.[75] In theory, he notes, the exemption should not be available to subsidize growth that employs capital less productively than do other economic activities.[76] However, the difficulties involved in measuring the productivity of nonprofit firms' investments[77] make him reluctant, absent a clear case, to deny exemption on this basis.[78] He therefore recommends that eligibility for the exemption turns "primarily" on whether there is "convincing evidence" that pur-

---

order to maximize current production or forego all production with marginal costs greater than the market price in order to maximize current earnings, thereby accumulating investment capital. Income taxation makes it less attractive for a firm to forego current production in order to accumulate earnings to invest in future production. Tax-paying nonprofits will therefore tend to stop accumulating earnings (and investing in future production) at lower output levels than will tax-exempt nonprofits, all else being equal. *Id.* at 77-80.

75. *Id.* at 86-87.

76. *Id.* at 86. The exemption, Hansmann suggests, could be denied to nonprofit firms that have expanded to the point at which the productivity of their invested capital drops below the pre-tax rate of return on capital invested in other industries. *Id.*

77. Hansmann, *Rationale*, *supra* note 58, at 86 n.90 (noting the difficulty of determining a nonprofit's marginal rate of return on a new investment). Hansmann does not discuss the reasons for these difficulties. They appear to arise primarily from the impossibility of objectively valuing outputs in many industries populated by nonprofits. Beneficiaries' subjective experience greatly influences the values of myriad goods and services that nonprofits supply. It is impossible to directly measure this influence. Even when beneficiaries pay market prices to nonprofit producers in exchange for goods or services, objective valuation of nonprofit output does not thereby become possible, because market failures tend to make price a poor surrogate for value.

The impossibility of objectively valuing nonprofits' output raises a more fundamental problem for Hansmann's theory of the exemption. Hansmann's approach rests on the premise that policymakers can identify those nonprofits that, owing to purchasers' lack of information about outputs, are likely to be more efficient than their for-profit competitors. Such identification, however, is impossible without a way to measure efficiency, and measurement of efficiency is not possible without a way to value outputs. If outputs cannot be valued in an objective and generally-accepted manner, then measurements of efficiency are bound to be the subject of continuing dispute, and Hansmann's test of eligibility for the exemption is, by itself, indeterminate. Hansmann himself illustrates this problem by being less than clear about the weight he would accord to purchasers' sense of trust as part of a nonprofit firm's output. *See supra* note 64 and accompanying text (noting that Hansmann does not quantitatively or relatively measure consumer trust). Without case-by-case decisions about what aspects of output should count for how much, Hansmann's approach to eligibility for the exemption cannot render decisive answers.

78. *Id.* at 86.

chasers' inability to monitor output gives nonprofits an efficiency advantage over for-profits in the industry at issue.[79]

2. The Market for Hospital Care and the Case for a Capital Subsidy

According to Hansmann, nonprofit hospitals probably do not meet this test and should "arguably" not be exempted.[80] Hospital patients, he concedes, lack the necessary information (medical knowledge) to meaningfully evaluate the services they receive. He points out, however, that patients do not buy hospital care on their own;[81] they rely upon their physicians to function as clinical purchasing agents. Because physicians are knowledgeable about hospital services, Hansmann asserts that they can competently monitor the outcomes of the purchasing decisions they make on their patients' behalf.[82] Because physicians act as fiduciaries to their patients, Hansmann explains, physician expertise renders patients able, in effect, to monitor outputs and to thereby impose market discipline upon hospitals.[83] Thus, Hansmann concludes, nonprofit hospitals probably lack the efficiency advantage over for-profits that would justify tax exemption.[84]

a. *Medical Ignorance, Institutional Authority, and the Calculus of Efficiency*

Hansmann's disinclination to extend the exemption to nonprofit hospitals may reflect a misplaced confidence in the ability and inclination of physicians to act as knowledgeable and loyal purchasing agents for their patients.[85] A strong case can be

79. Hansmann, *Rationale*, *supra* note 58, at 87.
80. *Id.* at 89.
81. Hansmann, *Nonprofit Enterprise*, *supra* note 9, at 866 & n.90.
82. *Id.* at 866.
83. *See id.* at 866-68 (explaining that patients, with physicians as their purchasing agents, are not necessarily at the mercy of for-profit hospitals).
84. Hansmann, *Rationale*, *supra* note 58, at 89.
85. Hansmann is hardly alone in his belief that patients can rely upon physicians to function as well-informed and loyal fiduciaries on their behalf. Kenneth Arrow's classic study of consumer ignorance in the medical marketplace presumed a high level of physician knowledge about medical outcomes and concluded that the medical profession had evolved an ethic of unselfish commitment to patients' interests in response to patients' fears that their medical ignorance might be exploited. Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 949-51 (1963). Arrow's premise of medical altruism echoed Talcot Parsons' earlier depiction of physician behavior as driven by a patient-oriented "collectivity orientation." TALCOT PARSONS, THE SOCIAL SYSTEM 428-47 (1951). More recently, Arnold Relman, a

made for the proposition that the medical profession is today neither able nor adequately motivated to protect patients from exploitation by hospitals. Several strands of reasoning support this proposition.

First, there is good reason to doubt the assumption that physicians possess sufficient knowledge about the outcomes of clinical interventions to act as well-informed purchasing agents for their patients. Popular perceptions of modern medicine as rigorously grounded in science[86] contrast starkly with health-services researchers' growing realization that most diagnostic and treatment measures are not well-supported by empirical evidence of efficacy.[87] Contemporary medical expertise enables physicians to make reasonably good ex post assessments of their patients' responses to clinical interventions. However, the paucity of empirical data on the probable results of diagnostic and treatment measures from an ex ante perspective, leaves physicians ill-prepared to make well-informed clinical recommendations and decisions.[88] As a result, medical decisions are more

---

former editor-in-chief of the New England Journal of Medicine and an outspoken opponent of hospital efforts to influence physicians' clinical decision-making via financial incentives, has sought to reconstruct the fiduciary commitment as a bulwark against patients' vulnerability to the economic pressures that now confront health care providers. Arnold Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963, 969 (1980). In an earlier article, I expressed confidence that the medical profession's fiduciary ethic could confer such protection. Bloche, *Corporate Takeover of Teaching Hospitals*, *supra* note 44, at 1099-1101. I am now more skeptical. *See infra* notes 88-113 and accompanying text (describing numerous structural obstacles that often prevent physicians from acting as their patients' loyal fiduciaries).

86. *See, e.g.*, Judy Foreman, *Medical Opinions Called Part Art, Part Science*, BOSTON GLOBE, May 15, 1993, at 15 (noting that while most patients expect certainty and objectivity from their doctors, "medicine is both art and science, an endeavor loaded with hidden value judgments").

87. *See, e.g.*, OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONG., ASSESSING THE EFFICACY AND SAFETY OF MEDICAL TECHNOLOGIES 7 (1978) (reporting that only 10 to 20 percent of medical procedures have been empirically shown to be efficacious); John E. Wennberg, *Dealing with Medical Procedure Variations*, HEALTH AFF., Summer 1984, at 6, 30-31 (discussing "ambiguous or incomplete scientific evidence on the value of specific services").

88. This realization has inspired a surge of interest in medical outcomes research as a way to rationalize clinical decision-making. *See* Wennberg, *supra* note 87, at 31 (noting that physicians have responded favorably to medical outcomes research). The federal government has thrown its support behind the new outcomes research movement, creating a new agency to oversee and finance such research. *See* Lynn Wagner, *Outcomes Research Gets Budgetary Blessing*, 19 MOD. HEALTHCARE 45 (Nov.-Dec. 1989) (describing financial allocations for outcomes research projects); Charles Marwick, *New Health Care Research Agency Reflects Interest in Evaluating Quality*, 263 JAMA 929 (1990) (describing the structure and functions of this new agency). At least in the

susceptible to non-rational influences, including the blandishments of hospital administrators,[89] than would be the case were medical judgment informed by comprehensive empirical data about clinical outcomes. Abundant evidence that treatments for many illnesses vary according to clinical settings[90] underscores the potential significance of these influences on medical judgment. For most such variations, the current state of medical knowledge does not support a preference for one option over others.[91]

Hospital managers are increasingly able and inclined to exploit this opportunity to influence clinical care. New reimbursement schemes, enhanced administrative authority, and emerging tort doctrines that hold hospitals liable for staff physicians' negligence now give hospital managers unprecedented power and incentive to influence physician judgment.

By paying hospitals on the basis of diagnosis, irrespective of the inpatient services actually ordered by physicians, the 1983

---

short term, it is unlikely that outcomes research will transform medical decision-making into a largely scientific endeavor. The vast diversity of clinical situations renders the scientific validation of medical practice an enormous undertaking. This undertaking will be further complicated by the need to exclude many real-life clinical circumstances from a clinical trial in order to define a sample sufficiently homogenous to generate meaningful results, the difficulty of developing reliable inclusion criteria for clinical trials, and related uncertainty about whether particular clinical circumstances that arise in practice are sufficiently like those studied in an experimental trial to warrant predictions about efficacy based on trial results. *See generally* William H. Havener et al., *Clinical Decision Making: Theory vs. Practice*, 264 JAMA 1533, 1533-34 (1990) (raising potential problems and shortcomings of medical outcomes research). The high cost of clinical trials poses another barrier to the scientific validation of medical practice.

89. Other non-rational influences include deference to authority (*see* Eric Marcus, *The Role of Liaison Psychiatry in the Clinical Training of Medical Students: A Psychoanalytic Approach*, *in* CONSULTATION-LIAISON PSYCHIATRY: CURRENT TRENDS AND NEW PERSPECTIVES 267, 267-84 (Jerry B. Finkel ed. 1983) (detailing the fear, shame, and intimidation most medical students feel upon their entry into a clinical setting)), the charismatic influence of senior teachers and practitioners (*see* Lester S. King, *Listening to a Different Drummer*, 261 JAMA 2691 (1989) (illustrating the role of influential contacts in guiding career choices)), cultural biases such as Americans' favorable attitudes toward high technology (STANLEY J. REISER, MEDICINE AND THE REIGN OF TECHNOLOGY 229-30 (1978) (describing the influential power of technology)), and the promotional activities of pharmaceutical firms and medical equipment companies.

90. Wennberg, *supra* note 87, at 9-15.

91. John E. Wennberg, *The Paradox of Appropriate Care*, 258 JAMA 2568 (1987) (describing a study which found "little" relationship between variations in procedure and appropriateness).

Medicare reimbursement reforms[92] inspired new efforts by hospital officials to reduce physicians' utilization of services. Such efforts have included the monitoring of physician practice patterns with an eye toward requiring more costly providers to account for their behavior,[93] and the payment of bonuses to staff physicians who turn annual "profits" for their hospitals by keeping Medicare patients' costs below their diagnosis-based revenues.[94] Some private insurers have adopted similar, diagnosis-based hospital reimbursement schemes,[95] heightening the pressure on hospitals to induce physicians to practice more cheaply.

Medical practice within Health Maintenance Organizations ("HMOs"), which are financed on a capitation basis,[96] is even more susceptible to managerial influence. Staff physicians at HMO-owned hospitals are typically HMO employees. Many HMOs pay their physicians in a manner expressly designed to create financial incentives to order fewer services.[97] Even when

92. Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65, 149-72 (1983) (codified at 42 U.S.C. § 1305). These reforms changed Medicare reimbursement from a retrospective, cost-based process to a prospective payment mechanism tied to diagnostic categories. *See generally* Gilbert S. Omenn & Douglas A. Conrad, *Implications of DRGs for Clinicians*, 311 NEW ENG. J. MED. 1314 (1984) (explaining the reforms and projecting their affect on the medical industry).

93. A study of 42 Massachusetts hospitals found that when medical staff organizations became involved in clinical decision-making, costs were significantly restrained. The medical staff as a group would devise cost standards and monitor individual practitioners to limit variations. Omenn & Conrad, *supra* note 92, at 1315.

94. The Paracelsus Healthcare Corp. of Pasadena, California, which operated a chain of for-profit hospitals, created an incentive program for physicians that has since been made illegal. Under the old incentive plan, a hospital that profited on a Medicare or Medicaid patient during any month would give the attending physician a cut of the profit. *New Legislation Forces Paracelsus to Rework Incentives*, HOSPITALS, Dec. 5, 1987, at 22. A federal statute enacted in 1986 prohibited hospitals from making incentive payments to physicians to reduce services to Medicare or Medicaid beneficiaries. Pub. L. No. 99-509, 100 Stat. 2003 (1986) (codified at 42 U.S.C. § 1320a-7a).

95. Janet Firshein, *Pediatric Hospital Group Lobbies for Children's DRGs*, HOSPITALS, Oct. 20, 1986, at 28 (reporting that by 1986, seven Blue Cross plans had created DRG-based hospital reimbursement schemes).

96. HMOs finance hospital care via fixed annual prepayments from members (individuals or families). HMO managers thus have a powerful incentive to press physicians to hold down their utilization of hospital services.

97. Typical mechanisms include capitation payments to individual primary care physicians, bonus payments to individual or groups of physicians who spend less than the amount budgeted to them for the services they order, and the withholding of some portion of physicians' anticipated income so that annual adjustments, upward or downward, can be made based on physicians' ordering behavior. Alan L. Hillman et al., *HMO Managers' Views On Financial Incentives and Quality*, HEALTH AFF., Winter 1991, at 207, 210.

management does not *openly* pay its physicians more for doing less,[98] organizational imperatives usually influence HMO-employed physicians to restrain inpatient spending.[99]

Hospital managers have moved aggressively during the last ten years to assert authority over medical decision-making. In some cases, they have changed hospital bylaws to permit consideration of physicians' clinical spending patterns in determining medical staff privileges.[100] They have developed "educational" programs to persuade physicians to weigh hospital financial concerns when making clinical decisions, while attempting to establish and enforce protocols for frugal practice.[101] Indeed, some scholars of health policy have encouraged such developments and urged that legal barriers to managerial control over medical decision-making be broken down, pointing to physician discretion as a primary factor in rising health care costs.[102]

---

98. *See* Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment,* 137 U. PA. L. REV. 431, 483-93 (1988) (discussing individual and group incentives that are likely to withstand legal scrutiny).

99. *See* Alain Enthoven & Richard Kronick, *A Consumer-Choice Health Plan for the 1990's: Universal Health Insurance in a System Designed to Promote Quality and Economy,* 320 NEW ENG. J. MED. 94, 95-96 (1989) (arguing that the financial success of HMO's and other prepaid plans will depend in large measure on their ability to develop collaborative relationships with participating physicians).

100. Average length of stay, charges per patient, and frequency of insurer refusal to pay for hospital services are among the measures of physician economic performance that hospital administrators have sought to weigh. Leonard E. Cantrell, Jr. & Jeffrey A. Flick, *Physician Efficiency and Reimbursement: A Case Study,* HOSP. & HEALTH SERVICES ADMIN. 43, 45-46 (1986). Hall, *supra* note 98, at 486 n.194 (reporting on use of spending patterns as one of the factors with which to construct a physicians efficiency index). In some states, hospital officials may be legally barred from changing medical staff bylaws without obtaining medical staff consent. *See, e.g.*, St. John's Hosp. Medical Staff v. St. John Regional Medical Ctr., Inc., 245 N.W.2d 472, 475 (S.D. 1976) (bylaws adopted by medical staff and approved by hospital governing body constitute a contract, binding both governing body and medical staff). On the other hand, courts have permitted hospitals to deny staff privileges to physicians based in part on physicians' economic performance. *See, e.g.*, Knapp v. Palos Community Hosp., 465 N.E.2d 554, 560 (Ill. App. Ct. 1984) (physician's unusually long lengths of stay and unusually high hospital costs held relevant to hospital decision to deny staff privileges).

101. Hall, *supra* note 98, at 480-83.

102. *Id.* at 488-93. There are two main types of legal constraints on financial incentives created by hospitals for physicians. One focuses on the splitting of fees between hospitals and referring physicians as an inducement to treat. The other focuses on fee splitting as an inducement *not* to treat. The Medicare-Medicaid fraud and abuse statute exemplifies the former restriction on referral fees by providing penalties of up to five years in prison and a maximum $25,000 fine for physicians who receive such fees. Omnibus Budget Reconciliation Act of

Hospital authority over medical decision-making has been reinforced by a series of recent court decisions holding hospitals responsible for the clinical actions of independent physicians with staff privileges. The institutional liability of hospitals has grown to encompass failure to exercise reasonable care in conferring staff privileges,[103] failure to perform periodic review of staff physicians' competence,[104] and the failure to supervise inpatient treatment provided by staff physicians.[105] In expanding hospital liability along these lines, courts have endorsed a model of medical decision-making that casts the hospital as an active participant, in contrast to Hansmann's portrayal of the hospital as a passive supplier of services ordered by physicians.

Cost-conscious third-party payers are also constraining physicians' clinical decision-making. During the last decade, insurance companies and self-insuring employers that pay for care on a per-service basis have adopted increasingly restrictive utilization review and managed care programs.[106] Third-party payers now commonly require physicians to obtain approval from utilization reviewers before proceeding with hospital treatment. Other strategies for controlling hospital costs make use of "gatekeeper" physicians[107] or insurance company "case managers" who possess the authority to approve or deny payment for inpatient stays. An increasing number of insurers are contracting with physicians, who agree to cooperate with an insurer's

---

1990 (OBRA 90), 42 U.S.C. § 1395nn(b) (1992). Another federal statute exemplifies the latter restriction by mandating penalties of up to $2000 against a hospital that provides incentives to limit services to Medicare or Medicaid patients. OBRA 90, 42 U.S.C. § 1320a-7a (1992).

103. Johnson v. Misericordia Community Hosp., 301 N.W.2d 156, 174 (Wis. 1981) ("[A] hospital owes a duty to its patients to exercise reasonable care in the selection of its medical staff and in granting specialized privileges.").

104. Elam v. College Park Hosp., 132 Cal. App. 3d 332, 341-42 (1982) (holding that the hospital owed a duty of care which included periodic review of physicians' competency before reappointments and before renewal of staff privileges).

105. Darling v. Charleston Community Memorial Hosp., 211 N.E.2d 253, 261 (Ill. 1965) ("[I]t was the duty of the hospital to supervise the competence of its staff members.").

106. Elizabeth W. Hoy et al., *Change and Growth in Managed Care*, HEALTH AFF., Winter 1991, at 18, 22-23.

107. Gatekeeper physicians are typically primary care clinicians who agree to abide by an insurer's utilization management program. Insurers employing this strategy, known as a point-of-service plan, require each subscriber to select a gate-keeping physician. The gatekeeper controls access to specialized and inpatient care. Whether paid on a capitated or fee-for-service basis, gatekeepers are given financial incentives to discourage specialty referrals and utilization of hospital services.

clinical practice protocols and utilization management program in exchange for status as "preferred providers." In turn, such insurers offer patient-subscribers financial incentives to choose preferred provider physicians. Many third-party payers now monitor the practice patterns of physicians with an eye toward persuading high spenders to change their behavior. Some insurers use practice pattern data to exclude high-spending physicians from preferred provider lists.[108]

Such management strategies are transforming the conditions of medical practice. Between 1987 and 1990, the portion of insured employees covered by conventional plans[109] without utilization management programs dropped from forty-one to five percent.[110] During the same period, the percentage of insured employees covered by conventional plans with utilization management rose from thirty-two to fifty-seven, and the percentage covered by insurer-administered managed care systems[111] rose from twenty-seven to thirty-eight.[112] The growing influence of third-party payers on physician judgment does not necessarily further the interests of hospitals at patients' expense.[113] It does, however, contribute to the erosion of physicians' clinical independence, and can operate to put physicians' interests into heightened conflict with those of their patients.

In view of medical ignorance about clinical outcomes and mounting pressure on physicians to compromise the interests of their patients, Hansmann's belief in physicians' ability to act as effective purchasing agents for patients appears unwarranted. The role of hospital managers in decision-making about the use of clinical services is well established and likely to expand. Without well-informed purchasing agents committed to acting as fiduciaries, patients lack the capacity to evaluate clinical op-

108. Amy Goldstein, *Area Doctors Rated by Cost: Blue Cross to Use Data to Refuse Patients*, WASH. POST, July 10, 1992, at A1. Blue Cross and Blue Shield created a health care network for federal employees in the Washington, D.C., area, offering preferred status to physicians with lower costs. *Id.*

109. Conventional health insurance plans provide cost-based or charge-based payments to hospitals and fee-for-service payments to physicians.

110. Hoy et al., *supra* note 106, at 19.

111. Insurer-administered managed care systems include point-of-service plans, HMOs, and preferred provider organizations (PPOs).

112. Hoy et al., *supra* note 106, at 19.

113. Where insurers pay hospitals on a cost or charge-based basis, insurers' efforts to discourage physicians from using inpatient services operate contrary to hospitals' interests. Moreover, one might argue that cost-conscious insurers and patients ex ante the onset of illness have similar interests, since reductions in insurers' costs redound, at least in part, to the benefit of those who pay insurance premiums (beneficiaries and their employers).

tions and outcomes. They are therefore unable to impose meaningful market discipline on hospitals. A strong case can thus be made for the efficiency-enhancing significance of the nonprofit form as a safeguard against the exploitation of patients by hospital managements.

Whether this efficiency-enhancing effect is large enough to justify the per se income tax exemption of nonprofit hospitals is a distinct question lacking an easy answer. Hansmann's capital subsidy rationale for the exemption requires that efficiency gains from the non-distribution constraint's real or perceived protection against exploitation outweigh the advantages classical economics finds inherent in the for-profit form by virtue of its need to generate income for its owners. Unfortunately, a determinate valuation of the countervailing efficiencies that derive from the non-distribution constraint and the for-profit form is impossible.

Production costs, it is true, can be measured in dollar amounts.[114] Moreover, some aspects of clinical output can be valued quantitatively—data on the years of life saved by particular diagnostic and treatment measures are a primary example. However, much about medical care cannot be evaluated objectively.[115] Individual patients' experiences of illness, disability, and treatment are intensely subjective, highly variable, and not open to quantitative assessment.[116] Feelings of trust or suspicion engendered by a hospital's organizational form are difficult

114. This presumes a decision not to "count" emotional and moral costs, such as psychic distress and affronts to important moral commitments, incurred by service providers under alternative organizational forms. *Cf.* GUIDO CALABRESI, IDEALS, BELIEFS, ATTITUDES, AND THE LAW 69-86 (1985) (offering arguments against accounting for psychic and moral harms).

115. By objectivity, I do not mean to exclude normative bias, which is built into the design of every empirical inquiry. Normative selectivity enables systematic empirical study, allowing the willingness, whether open or implicit, to disregard unframed issues, unasked questions, and unobserved parts of reality. The weaker form of objectivity I refer to entails the choice of variables that can be assayed "reliably" (as statisticians use this term), meaning a measurement with consistent results, deriving from visible facts and shared biases.

116. The Oregon Health Services Commission made an attempt at quantifying attitudes toward different illnesses in 1989. The governor of Oregon appointed a group of 11 health professionals and lay people to prioritize health services for funding. It used community meetings and a telephone survey of 1001 individuals to assign numerical scores to various sets of health symptoms. *See* Harvey D. Klevit et al., *Prioritization of Health Care Services: A Progress Report by the Oregon Health Services Commission*, 151 ARCHIVES INTERNAL MED. 912, 912-16 (1991) (reporting on Oregon experience with quantitative assessment of people's attitudes toward illnesses and discussing difficulties involved in such assessments).

to trace and impossible to tally. The efficiencies associated with the non-distribution constraint thus cannot be assayed directly and objectively, as long as patients' subjective experience is deemed to matter.

In view of this practical difficulty, the market behavior of patients arguably merits some weight in evaluating the efficiencies that derive from the nonprofit form. Contrary to the predictions of some in the early 1980s,[117] nonprofit hospitals continue to dominate the market for inpatient care.[118] This suggests that patients may perceive value in the non-distribution constraint as a safeguard against exploitation of their medical ignorance.[119] Whether nonprofit dominance might reflect patients' preferences is a disputed question. Some skeptics dismiss nonprofit dominance as the product of self-interested physicians' control over hospital selection,[120] but the image of servile patients who play no part in the choice of a hospital squares poorly

117. In 1985 Frost & Sullivan, Inc., a New York City-based market research firm, predicted that for-profit hospitals would increase their 14% market share of beds to 30% by 1990. This figure represented both acute care general-hospital and specialty-hospital beds, although Frost & Sullivan expected the latter to multiply more rapidly. Glenn Richards, *Study Projects Major Growth for For-Profits*, HOSPITALS, Nov. 16, 1985, at 29.

118. AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS 20 (1994-95 ed., 1994) (reporting that in 1993, nonprofit hospitals had 157,827,023 days of inpatient care while for-profit hospitals had only 18,410,447 days).

119. Hansmann dismisses the continued market dominance of nonprofit hospitals as a mere historical artifact, irrelevant to the present-day calculus of efficiency. Hansmann, *Nonprofit Enterprise*, *supra* note 9, at 867. His skepticism about this market outcome as a metric of efficiency contrasts with his usual deference to market measures of the nonprofit form's value, especially his assumption that nonprofit firms' retained earnings and net income reflect past and present excess demand. *See supra* text accompanying notes 71-74 (discussing conditions of competitive equilibrium in the health market) .

120. Physicians, this argument holds, prefer the nonprofit form because for-profit hospital managers exert firmer control over clinical care, thereby holding down physicians' fees. By contrast, physicians influence, even control, nonprofit hospital managements, enjoying greater freedom to pursue higher incomes. As a result, these critics claim, the medical profession steers unknowing patients to nonprofit hospitals, thereby maintaining nonprofit dominance. *E.g.*, Robert Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1416, 1441-47 (1980) (arguing that income maximizing physicians exploit the not-for-profit form, benefitting from the increased power in decision-making); Mark Pauly & Michael Redisch, *The Not-for-Profit Hospital as a Physicians' Cooperative*, 63 AM. ECON. REV. 87, 87 (1973) (proposing an economic model for not-for-profit hospitals in which the physician emerges as a traditional income maximizing agent).

Advocates of this view have produced no evidence to show that for-profits exercise more control over clinical care than nonprofits, or that physicians who admit patients to for-profit hospitals charge less than those who send patients to nonprofits. Their argument carries even less weight today, in light of the

with the recent emergence of patients as active participants in other decisions about their care. Moreover, even if patient preferences for the nonprofit form reflect illusory notions about the protection it affords, these preferences merit a place in the calculus of efficiency, as long as trust is considered important in medical care.

b. *Are Nonprofit Hospitals Over-Capitalized?*

The case for the efficiency advantage of the non-distribution constraint over the for-profit form in the hospital industry is less than compelling. Yet it is stronger than Hansmann's work recognizes. Perhaps aware of this,[121] Hansmann also argues that nonprofit hospitals fail his other criterion for exemption—the ability to employ new capital more productively than what is average for other economic activity.[122] Although he finds the administration of this criterion too difficult to feasibly apply in most cases, he contends that nonprofit hospitals are overcapitalized, and thus unable to achieve high enough productivity from new investments to justify the capital subsidy that the exemption provides.[123]

In asserting the overcapitalization of the nonprofit hospital industry, Hansmann relies upon congressional pronouncements to this effect.[124] Critics of the American hospital industry commonly argue that the industry is overbuilt[125] and too technology-intensive.[126] They usually attribute this to market failure

---

mounting pressure on nonprofit hospitals to influence physician decision-making. *See supra* text accompanying notes 100-105.

121. Hansmann tentatively expressed disbelief in the non-distribution constraint's efficiency advantage. *See* Hansmann, *Rationale*, *supra* note 58, at 89 (suggesting that hospitals "arguably fail" this criterion and that market flaws resulting from patients' medical ignorance "do not seem important" for most hospital services).

122. *See supra* text accompanying notes 60-68.

123. *See supra* text accompanying notes 66-79.

124. Hansmann, *Rationale*, *supra* note 58, at 89 n.102 (citing findings that inpatient facilities were in excess supply, contained in Senate committee reports accompanying the National Health Planning and Development Act of 1974, and the 1979 amendments to this Act).

125. *See, e.g.*, Dennis B. Dorsey, *The Other Health Care Revolution*, 110 ARCHIVES PATHOLOGY & LABORATORY MED. 264, 265 (1986) (stating that many hospital administrators have built physical plants that are "indistinguishable from luxury hotels"). In 1989, American hospitals operated at an average occupancy level of only 69.6%. The average occupancy rate has remained below 80% since 1971. AMERICAN HOSPITAL ASS'N, *supra* note 48, at 2.

126. U.S. hospitals often receive criticism for premature adoption of unproven technologies. *See, e.g.*, Charles A. Sanders, *Adoption of New Technologies in Hospitals*, *in* CRITICAL ISSUES IN MEDICAL TECHNOLOGY 25, 25-36

arising from third-party payment of most inpatient expenses. Insulated by third-party payers from the actual cost of care, hospital patients purchase clinical services with little regard for price. This price insensitivity, the classic argument holds, leads to artificially high demand, often termed "moral hazard."[127] To be authentic, demand must reflect the market choices of consumers who themselves bear the cost of the services they purchase.[128] Because demand (and willingness to "pay" by passing costs to third parties) is artificially high, hospitals overinvest relative to what they would do in a well-functioning market populated by self-paying consumers.

This account privileges the imagined outcome of a hypothetical marketplace populated by uninsured, self-paying consumers.[129] American mechanisms of third-party payment, however, are themselves products of the marketplace. They have been shaped not only by such distorting factors as the personal income tax exemption for employer contributions toward workers' health insurance,[130] but also by consumers' anxieties and fears. As the economist Rashi Fein has noted (and as many health economists fail to acknowledge), people buy more health insur-

(Barbara J. McNeil & Ernest G. Cravalho eds., 1982) (describing how the unproven technology of gastric freezing was prematurely accepted, used abundantly, then discarded when researchers found it to be ineffective).

127. The term "moral hazard," often used to describe the propensity of third-party payment to increase demand, conveys economists' traditionally dim view of the effects of insulating consumers from purchase prices. The term reflects concern that consumers, so insulated, might demand services that would not be provided by a well-functioning market because their true costs outweigh their benefits.

128. ALAIN ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COSTS OF MEDICAL CARE xvi (1980) (stating that since the benefits of health care are difficult to quantify, the best way to measure the value is to have the recipients pay for it with their own current funds to insure that the services are "worth the cost"). *See also* Gavin Mooney & Alistair McGuire, *Economics and Medical Ethics in Health Care: An Economic Viewpoint*, *in* MEDICAL ETHICS AND ECONOMICS IN HEALTH CARE 5, 8-9 (1988) (arguing that only the patient can attach value to a potential improvement in health status).

129. To avoid flagrant unfairness, this account must also presume that each of these hypothetical, uninsured consumers has enough wealth to afford care when its benefits outweigh its costs.

130. *See Employee Benefit Items: Elimination of Tax Subsidies for Employer-Sponsored Health Insurance Could Reduce Health Care Costs*, 8 TAX MGMT. FIN. PLAN. J. 261, 261 (1992) (blaming the health insurance tax exemption for medical overspending because it hinders the free-market incentive to limit costs); *see also* Martin & Kathleen Feldstein, *Cut the Health Insurance Subsidy*, WASH. POST, Dec. 16, 1992, at A27 (arguing that by subsidizing health insurance provided by employers, the current tax system creates an incentive for individuals to overinsure themselves).

ance than makes actuarial sense, given their premiums, probabilities of illness, and abilities to bear financial loss.[131] Whether they obtain coverage independently or through the workplace, Americans seek not only protection from catastrophic financial loss, but also freedom from the need to balance their own or their loved ones' health against the cost of care, should illness threaten.[132]

It is thus not obvious that one should take the hypothetical choices of imaginary uninsured, self-paying customers as the correct measure of market demand, and hence as the proper basis for determining the optimal level of capital investment. Actual consumers' decisions to insure against the need to put a dollar value on health should illness strike represent an alternative measure of market demand. "Moral hazard," in other words, can represent a circumstance *chosen* by consumers in the marketplace. From this perspective, the extra demand for medical care induced by third-party payment becomes a product of market choice rather than market failure, and the added investment generated by this extra demand can be accepted as appropriate.

One need not adopt this alternative perspective to acknowledge its plausibility. It cannot be dismissed in favor of the market failure perspective without an independent argument to the effect that the level of medical spending now engendered by third-party payment is too high.[133] Absent such an argument, one can defend the nonprofit hospital industry's overall capitalization as a reflection of consumer preferences.[134] This makes it

131. Fein persuasively argues that the actuarial irrationality of consumers' health insurance purchases cannot be fully explained by federal tax subsidies. One must also consider the welfare gains associated with peace of mind. Rashi Fein, *Social and Economic Attitudes Shaping American Health Policy*, 58 MILBANK MEMORIAL FUND Q. 349, 378 (1980).

132. This latter concern is distinct from financial risk aversion. Financially risk-averse individuals place disproportionate weight on the prospect of economic loss, relative to its actual probability. Persons who wish to avoid making explicit choices between their own or their family's health and their bank balances are averse to open valuation of their own and their loved ones' well-being in dollar terms. This latter aversion is akin to Guido Calabresi's "cost of costing," the affront to human dignity that flows from explicitly valuing lives in dollars. GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES 32 (1978). It is, however, more personal, for it entails an affront to one's feelings of self-worth or love and commitment to others.

133. Such an argument must assert a preference among competing resource uses: between inpatient care and other medical services, or between health care more generally and myriad other social needs.

134. Although criticism of American health care spending levels has become commonplace, consumers continue to show their willingness to sacrifice greatly

problematic to characterize new hospital investment as insufficiently productive (compared to investment in other economic activity) to warrant tax exemption based on Hansmann's capital subsidy rationale.[135]

3. Medical Need and Per Se Exemption as a Capital Subsidy

Nonprofit hospitals, in short, can make a plausible claim for exemption as a subsidy to capital formation based on the efficiency advantages of the non-distribution constraint and the productivity of their capital investments. This presumes, however, that nonprofit hospitals' earnings are an adequate measure of excess health care need (which Hansmann equates with demand)[136] and thus of unmet capital need.[137] This presumption glosses over two more serious problems for the capital subsidy rationale.

First, when information problems reduce purchasers' ability to evaluate the quality of a good or service, the non-distribution constraint offers imperfect protection against the exploitation of purchasers' ignorance. Because the non-distribution constraint applies only to financial emoluments,[138] it gives free rein to non-

---

to maintain insurance that assures their access to costly, state-of-the-art technology. So long as individual Americans are so inclined, medical spending is likely to rise. *Cf.* Daniel R. Waldo et al., *Health Spending Through 2030: Three Scenarios*, HEALTH AFF., Winter 1991, at 231 (projecting that health care expenditures will reach 26.1% of GNP by the year 2030 if current programs, regulations, and practices continue).

135. *See supra* notes 60-79 and accompanying text (describing Hansmann's capital subsidy model).

136. *See supra* notes 70-74 and accompanying text (describing Hansmann's theory that one can equate a nonprofit firm's earnings with demand).

137. *See supra* 65-68 and accompanying text (describing how the non-distribution constraint handicaps a nonprofit firm's ability to raise capital).

138. This restriction is hardly airtight: nonprofit firms commonly distribute financial rewards to senior executives in the form of high six-figure salaries and luxurious perquisites. *See* Joan Lampert & David Bjork, *Annual Survey: Executive Compensation Under Fire*, HOSPITALS, Sept. 5, 1992, at 24, 27 (citing a survey putting average compensation for chief administrators in large nonprofit hospitals at $235,800 annually); *see also* Elizabeth Hudson, *United Way in Texas Feels Backlash from Scandal*, WASH. POST, Mar. 22, 1992, at A16 (reporting on controversy that erupted when United Way revealed that William Aramony received an annual salary of $390,000 as president of United Way of America).

Until recently, the IRS tolerated such salaries, but a shift toward greater skepticism may be underway. The IRS has begun to compare for-profit and nonprofit entities with an eye toward whether exempt organizations overcompensate its executives. Among the stratagems that have become the foci of IRS attention is the division of executive compensation among several subsidiaries to obscure actual totals. *Health Care, GCMs Being Developed by IRS to Resolve*

profit executives and trustees intent on using institutional resources to pursue personal, non-financial ends. In particular, nonprofit hospital managers are not prevented from pursuing major capital projects, for example, new construction and technology acquisitions, that yield personal prestige even when the clinical benefits are dubious.[139] Such projects require investment capital, which must come either from retained earnings or, more typically, new debt made possible by investor confidence in hospitals' future revenue prospects.[140] This tempts hospital managements to enhance revenues by exploiting market information problems. To the extent that hospitals do this, their earnings are a flawed measure of unmet medical and capital need.[141]

The importance of this problem is contingent upon where one locates society's "decision" to proceed with such capital-intensive projects. To avert financial failure, such projects must win the acceptance of patients and third-party payers. If responsibility is attributed to ambitious hospital executives, and if purchasers' willingness to underwrite architectural indulgence and unproven technology is ascribed to poor information, then income accrued by hospitals bent on expansion seems a flawed measure of clinical and capital need.[142] Alternatively, the willingness of patients and third-party payers to bear the cost of new construction and novel technologies reflects a popular faith

---

Open HMO-Related Issues, Sullivan Says, DAILY REP. EXECUTIVES, Oct. 20, 1992, at 203.

139. One can characterize this self-serving tendency, sometimes referred to as the "edifice complex," *e.g.*, Hall & Colombo, *supra* note 35, at 370, alternatively as wasteful (when discernable clinical benefit is doubtful) or as an economically rational response to the satisfaction that patients and society derive from advanced medical technology and the delivery of care in physical settings that evoke the aura of leading-edge science.

140. Private donations are today an insignificant source of capital for nonprofit hospitals. ANDERSON ET AL., *supra* note 40, at 147-48.

141. To some extent, countervailing (downward) influences on nonprofit hospital earnings cancel this effect. These include high salaries paid to senior executives, *see supra* note 138 and accompanying text, and the indirect benefits derived by independent physicians with staff privileges, for whom hospital employees perform myriad clinical and administrative tasks. Pauly & Redisch, *supra* note 120, at 88-89.

142. Strictly speaking, additional income generated (by exploiting purchasers' ignorance) to support expansion of service intensity in excess of what purchasers would want in the absence of information problems, is a spurious indicator of capital need. In practice, agreement regarding how much of a hospital's income can be so described will probably be impossible, since the preferences of hypothetical purchasers not shackled by information problems are susceptible to conflicting understandings.

in the healing power (or aura) of technology.[143] Understood this way, income accrued by hospitals to finance capital expansion more accurately signals clinical and capital need, since such income reflects purchasers' preferences.[144]

A second problem is more troubling. The notion that hospital earnings are an adequate measure of unmet clinical and capital need rests on the premise that patients' willingness and ability to pay for hospital care accurately reflect the national need for inpatient care. To the degree that some Americans' ability to pay for medical care is diminished, this premise is flawed. The harsh truth that more than 70 million Americans are either uninsured or poorly insured[145] suggests that this flaw is profound. These persons have unmet medical needs that they cannot express as buyers in the marketplace. Hospital earnings reflect neither these medical needs nor the capital requirements that these needs create. The capital subsidy rationale thus fails to take account of the needs of persons who are financially unable to obtain hospital care.

Moreover, the capital subsidy model deals perversely with the capital needs of hospitals that provide high levels of uncompensated care. This perversity arises because the burden of uncompensated care falls unevenly upon the nonprofit hospital industry. Facilities located in impoverished inner city and rural areas care for much higher proportions of non-paying patients than do other nonprofit hospitals.[146] Hospitals in such areas thus confront more difficult financial conditions. Their net earnings tend to be lower than those of similarly-sized nonprofit hos-

143. To some degree, this analysis reinterprets consumer knowledge as consumer preference. Instead of focusing on health care purchasers' "poor information" (and thereby portraying them as pushed along passively by others' decisions), it emphasizes the cultural and other biases that influence purchasers' information-gathering efforts and ultimate medical decisions. It thereby casts health care purchasers as active medical choosers.

144. This assumes that the preferences of purchasers (patients and third-party payers) are the appropriate measure of medical need. This assumption is open to challenge. *See, e.g.*, Charles A. Sanders, *Technology and the Hospital*, *in* MEDICAL TECHNOLOGY: THE CULPRIT BEHIND HEALTH CARE COSTS?, 57, 61, 71-72 (Stuart H. Altman & Robert Blendon eds., 1977) (contending that the specialized knowledge of physicians and researchers puts them in the best position to decide what new technologies need to be developed). Another problematic assumption is that the aggregate reimbursement behavior of patients and third-party payers is an appropriate measure of their preferences.

145. Tom Morganthau et al., *Health Care: Down to the Brass Tacks*, NEWSWEEK, May 17, 1993, at 36, 37.

146. *See supra* note 52 (describing the disproportionate number of nonpaying patients served by inner-city facilities).

pitals in prosperous areas. In recent years, many have suffered large operating losses, and increasing numbers have been forced to shut down.[147]

Not surprisingly, these facilities are less capable of generating needed capital[148] than are hospitals with lower proportions of non-paying patients. They are less able to accumulate equity capital in the form of retained earnings, and they have weaker borrowing power because ability to borrow is a function of one's current balance sheet and future revenue prospects. Such hospitals are therefore *more* in need of a subsidy for capital formation than are hospitals with high earnings and low indigent care burdens. However, the income tax exemption gives them a lower capital subsidy than it confers upon high-earning facilities that are less in need of a subsidy.[149] This mismatch between relative capital need and the distribution of the exemption's value further undermines the capital subsidy explanation.

In short, the case for the per se exemption as a capital subsidy is ultimately unpersuasive. Its unpersuasiveness derives primarily from the poor connection between a hospital's income, which determines the value of its exemption, and a hospital's clinical and capital needs.

C. Voluntarism and Virtue

An older justification for the per se exemption rests on a premise not readily cognizable in economic terms. The nonprofit form, this argument holds, merits special tax treatment because voluntarism is inherently virtuous. In contrast to the "public goods" and capital subsidy rationales, this argument is deontological in spirit. It presents tax exemption not as the price paid by society to obtain the benefits of voluntarism but instead as symbolic recognition and affirmation of voluntarism's virtues.[150]

147. *See* Sam Roberts, *Metro Matters: Breathing Life Into a Hospital*, N.Y. Times, Dec. 28, 1992, at B3 (describing a number of hospitals that have either closed or nearly closed in recent years).

148. This discussion assumes a conception of medical need not derived exclusively from the marketplace, a conception that incorporates clinical benefits and preferences that the market fails to translate into demand, typically because of some consumers' poor medical purchasing power. The discussion applies whether one understands medical need as objectively discernable, as socially and culturally constructed, or as mere private preference.

149. Hospitals that suffer operating losses benefit from the exemption only to the extent that they are nevertheless able to sell tax exempt debt instruments and to attract donations.

150. *See* Stevens, *supra* note 7, at 40-41 (describing state recognition of the benevolence of voluntaristic trustees and donors).

These virtues, the argument holds, can be neither produced nor purchased by the state. They are unique to voluntaristic organizations, and the best that government can do to encourage these virtues is to reward voluntarism as it occurs.

This argument has its roots in the "scientific charity" movement of the late 19th century.[151] It has been articulated in varying forms by nonprofit sector advocates since the advent of the progressive era.[152] Since the late 1980s, however, advocates for the nonprofit hospital sector have pressed this argument with increasing vigor in response to growing skepticism about the special tax treatment of nonprofits. Confronted with criticism of tax subsidies from both the right and the left, nonprofit hospitals have sought to distinguish their missions from those of the for-profit and government-run rivals.[153]

1. Four Claims to Virtue

As articulated by contemporary advocates, the voluntaristic virtues of nonprofit health care appear to fall into four categories: community solidarity, regard for religious and social diversity, preservation of personal freedom, and moral elevation of the healing role. Nonprofit hospitals are said to nurture community solidarity by providing common channels for giving and receiving. Although nonprofits today derive minimal operating and capital support from charitable sources,[154] the donations they do receive represent important symbols of their commitment to community. Along with the time contributed by community members, from trustees to candy stripers, this voluntarism is said to tie us together by symbolically affirming our moral du-

151. *Id.* at 19.

152. In permitting nonprofit hospitals to retain their property tax exemptions as they rapidly increased their percentages of paying patients, progressive era judges endorsed the voluntaristic ideal as an end in itself. The judiciary presumed that the benevolence of wealthy donors and voluntaristic trustees was worthy of state recognition, including property-tax exemption, regardless of how much service the hospitals in question provided to the poor. *Id.* at 41. The progressive-era ideology of voluntarism unabashedly proclaimed the importance of private benevolence for sustaining social acceptance of capitalism and America's uneven distribution of wealth. This paradox-laden ideology proclaimed the wealthy to be society's best stewards of public resources, even as it celebrated the insulation of hospitals and other voluntary institutions from "vulgar materialism." *Id.* at 18, 40.

153. *E.g.*, Seay & Vladeck, *supra* note 42, at 4-5, 33-34 (advocating tax subsidies and other public support for nonprofit hospitals on the basis of their distinctive "voluntary" mission).

154. *See supra* note 40 and accompanying text.

ties to neighbors.[155] Proponents of the voluntaristic virtues insist that the strength of this affirmation is not diminished by the fact that recipients of this voluntarism tend to be paying patients. On the other hand, they point with pride to the free care nonprofits do provide as a further expression of the moral significance of community.

The community solidarity ideal has undeniable evocative appeal. Yet as a virtue intrinsic to nonprofit status, it rings hollow. The self-satisfaction of the voluntaristic derives more from the act of giving than from an empathic relationship with the recipient.[156] Such self-satisfaction risks edging over into self-righteousness and even contempt.[157] To the extent that this occurs, the relationship between recipient and voluntaristic can take on an unpleasant aura of disdain and resentment, corroding any shared sense of community.[158]

In addition, the case for nonprofit-hospital care as an affirmation of community solidarity is undermined by the gap between voluntaristic symbolism and coercive reality. In the name of voluntarism and the pursuit of its virtues, nonprofit hospitals have benefited from mandatory "contributions" by some of society's least advantaged members. Until the 1940s, the doctrine of charitable immunity required victims of inpatient negligence to, in effect, subsidize nonprofit hospitals by sacrificing their tort claims.[159] Until 1983, the federal government did not require

155. Seay & Vladeck, *supra* note 42, at 8-9 (arguing for the significance of voluntarism in the "social fabric of America life").

156. Early 20th century voluntaristic ideology made this psychology explicit, where the virtues associated with giving accrued principally to the volunteer, not the recipient. *See* STEVENS, *supra* note 7, at 25-26.

157. *Cf.* Seay & Vladeck, *supra* note 42, at 26 ("A self-righteous indifference to those being served is a failing to which voluntary institutions may have been all too prone in the past.").

158. *Cf.* MICHAEL WALZER, SPHERES OF JUSTICE 92 (1983) (contending that private charity "breeds the familiar vices of dependence: deference, passivity, and humility on the one hand; arrogance on the other").

159. Some courts used implied contract theory to justify the doctrine of charitable immunity. The view was that the patient waived her right to legal action in exchange for free medical services. *See* President and Directors of Georgetown College v. Hughes, 130 F.2d 810, 811-27 (D.C. Cir. 1942) (recounting the history and development of the charitable immunity). By the 1940s, this premise of voluntary waiver began to be rejected as fictitious. *See id.* The demise of charitable immunity is now almost complete. *E.g.*, Wilson v. Lee Memorial Hosp., 65 So.2d 40 (Fla. 1953) (abolishing immunity for hospitals in Florida); Pierce v. Yakima Valley Memorial Hosp. Ass'n., 260 P.2d 765 (Wash. 1953) (abolishing immunity for hospitals in Washington); *see also*, CHARLES R. TREMPER, RECONSIDERING LEGAL LIABILITY AND INSURANCE FOR NONPROFIT OR-

nonprofit hospitals to enroll their workers in Social Security.[160] In addition, until 1974, nonprofit hospital employees, many of whom were and continue to be among the nation's lowest paid workers,[161] were not able to unionize under the protection of federal law.[162]

Today, these legal immunities have largely disappeared. However, voluntary contributions no longer support the charity care that nonprofit hospitals provide; insured and self-paying patients now supply most of the financing. These patients have little influence on hospital prices, which are set sufficiently high to subsidize the provision of free care.[163] This approach to financing "charity" is not merely compulsory; it is highly regressive. The percentage of personal income spent by insured Americans in this manner to support free hospital care is much higher for those with low incomes than for the upper-middle class and the wealthy.[164] Were this reality behind hospital charity to become more widely appreciated, dissatisfaction over its distributive impact could undermine hospital charity's community-affirming symbolic power.

Nonprofit hospitals have a stronger claim to virtue based on their traditional responsiveness to religious and social diversity. America's nonprofit hospitals developed largely in response to the yearnings of myriad groups for medical facilities of their own. During the 19th and early 20th century, leaders of ethnic, racial, and religious groups founded hospitals to serve their constituencies' particular cultural and spiritual needs.[165] The importance of spiritual concerns and cultural affinity to patients

---

GANIZATIONS 187-201 (1989) (summarizing state statutes and court decisions abolishing the charitable immunity doctrine).

160. Social Security Amendments of 1983, Pub. L. No. 98-21, § 102, 97 Stat. 65, 70-71 (1983) (codified as amended in various sections of U.S.C. Titles 26 & 42) (declaring Social Security taxes mandatory for nonprofit organizations, except schools, on the same basis as for businesses).

161. *See* Rhonda Ferrero-Patten, *Collective Bargaining Units in the Health Care Industry: The NLRB and Rulemaking*, 12 N. ILL. U. L. REV. 133, 136-37 (1991) (noting low wages and poor working conditions prior to Congress amending the National Labor Relations Act to remove the exemption for nonprofit hospitals).

162. Act of 1974, Pub. L. No. 93-360, 88 Stat. 395 (1974) (codified at 29 U.S.C. § 152 (1988)) (amending National Labor Relations Act to extend its coverage to employees of nonprofit hospitals).

163. *See infra* text accompanying notes 242-46.

164. *See infra* text accompanying notes 282-90.

165. *See* CHARLES E. ROSENBERG, THE CARE OF STRANGERS: THE RISE OF AMERICA'S HOSPITAL SYSTEM 109-11 (1987) (discussing the growth of Catholic hospitals during 19th century).

contemplating hospitalization was thereby affirmed and addressed by American voluntarism.[166] In recent decades, however, sectarian hospitals with disparate origins have come to offer convergent patient care experiences, spurred by clinical standardization and the homogenization of Americans' expectations about inpatient care.[167] Today, the technology-intensive experience of contemporary hospital treatment does not differ substantially according to a facility's religious or ethnic origins. The typical nonprofit hospital now draws an ethnically and religiously heterogeneous patient population. Geography, academic affiliation, and ability to pay have become more important than ethnic or religious ties as influences on the sorting of patients among hospitals.[168] Many sectarian hospitals maintain their spiritual commitments,[169] but they provide their patients with access to clergy of many faiths. The importance of social and religious particularity is much diminished today in the eyes of patients.

A more recent rendition of the nonprofit hospital's claim to virtue builds on the theme of personal freedom. In the late 1970s and throughout the 1980s, some advocates of nonprofit hospital care sought to recast voluntarism in free enterprise terms, drawing a dichotomy between state-mandated and entrepreneurial solutions to the problems of health care access and

166. This responsiveness to particularistic concerns had its ugly side, such as widespread racial, ethnic, and religious discrimination in patient admissions, hiring, and the selection of medical staff. Until the civil rights revolution of the 1960s, many nonprofit hospitals functioned openly as instruments of apartheid, banning black patients, physicians, and staff. *See id.* at 301-02 (describing the practice of segregating patients according to race).

167. The development of nationwide norms of hospital care and administration, as well as the eclipse of religious faith and ethnic affinity by esteem for medical science as a determinant of patients' expectations, have driven this process. *Id. Cf.* STEVENS, *supra* note 7, at 26 (noting that ethnic and religious affiliations with hospitals have weakened to the point that most religious hospitals are distinguishable from nonsectarian ones in name only).

168. Legal barriers also exist to insure that racial and religious affiliation do not affect access to health care. Racial discrimination by a hospital receiving funds under any HHS-administered program is prohibited. Sana Loue, *Access to Health Care and the Undocumented Alien*, 13 J. LEGAL MED. 271, 279 n.48 (1992) (citing DEPARTMENT OF HEALTH AND HUMAN SERVICES, GUIDELINES TO TITLE VI OF THE CIVIL RIGHTS ACT OF 1964); *see also* Title IV of the Civil Rights Act of 1964, 42 U.S.C. § 2000d (1988).

169. *E.g.*, Watkins v. Mercy Medical Ctr., 364 F. Supp. 799, 803 (D. Idaho 1973) (holding that Catholic hospitals can refuse to perform abortions or sterilization procedures on basis of religious repugnancy of those medical services), *aff'd.*, 520 F.2d 894 (9th Cir. 1975).

cost.[170] This transformed vision of voluntarism fit the increasingly commercial character of the nonprofit hospital industry. It emphasized the virtue of private inventiveness as an alternative to state coercion, and it decoupled the voluntaristic ideal from the ideal of charity. It empowered nonprofit hospitals, often in coalition with for-profits, to resist such governmental incursions as the Carter administration's bid to introduce hospital budget ceilings. In so doing, however, it undermined the nonprofit sector's claim to moral superiority over the for-profit sector, as investor-owned hospitals had at least an equal claim on the entrepreneurial virtues.

A fourth claim to virtue rests heavily on the viability of the previous three just discussed. Daniel Wikler contends that the moral goodness of medical care providers is of central importance because health care occupies such an intimate place in our lives.[171] This importance, Wikler argues, is both intrinsic and instrumental. Health care providers, in Wikler's view, need to have high moral standing because persons and institutions to whom we expose ourselves intimately should be worthy of our trust.[172] Moreover, the moral goodness of clinical caretakers inspires patient trust, which contributes to the efficacy of medical care. To the degree that nonprofit hospitals achieve the virtues of community solidarity, sensitivity to social and religious diversity, and preservation of personal freedom, they acquire moral standing that merits and invites patient trust. And to the extent that they are better able than for-profit hospitals to act on their patients' behalf in the face of market pressures, their trustworthiness is enhanced.

Wikler's argument incorporates this intuition, deeply felt by many clinicians, that the trustworthiness of medical caregivers plays an important role in the effectiveness of the care they pro-

170. STEVENS, *supra* note 7, at 319.

171. Daniel Wikler, *The Virtuous Hospital: Do Nonprofit Institutions Have a Distinctive Moral Mission?*, *in* IN SICKNESS AND IN HEALTH: THE MISSION OF VOLUNTARY HEALTH CARE INSTITUTIONS 127, 136-138 (J. David Seay & Bruce C. Vladeck eds., 1988) (arguing that health care is of the "highest personal importance" in an individual's life). Intimate exposure by patients to their doctors takes many forms. These include revelation of private life details, extraordinary physical exposure, and openness to professional advice regarding highly personal choices. For a discussion of the concept of intimacy and its relation to the broader issue of privacy, see generally ANITA L. ALLEN, UNEASY ACCESS: PRIVACY FOR WOMEN IN A FREE SOCIETY 19 (1988) (describing the nature of intimacy as associated with the larger concept of privacy).

172. Wikler, *supra* note 171, at 136-37 (contending that personal nature of the patient-provider relationship and professional status of providers require "virtuous" health care providers).

vide.[173] His argument is akin to Hansmann's case for the non-distribution constraint as a safeguard against the exploitation of market information problems.[174] Like the non-distribution constraint, the moral standing of clinical caregivers signals patients that caregivers are disinclined to exploit patient ignorance and powerlessness.[175] This moral signaling is less logical and more symbolic or connotative in content than the non-distribution constraint, which Hansmann sees as a rational basis for sometimes preferring the nonprofit form on efficiency grounds. Wikler's moral signaling relies instead on the tendency of persons, correctly or incorrectly, to form generalized impressions of goodness and trustworthiness in response to more particular indications of virtue.

Wikler's argument has some force, especially if one believes that patients' trust in their clinical caretakers enhances the therapeutic effectiveness of medical care. Yet its force is limited by the previously discussed weaknesses in the nonprofit hospital's other claims to virtue, since the argument depends heavily upon them. To the extent that Wikler's argument rests upon the merits of these claims in themselves, as opposed to patients' subjective impressions of the nonprofit form's virtues, it is undermined by these weaknesses.

Further problems arise from a disconnect between Wikler's institutional worthiness argument and the daily experience of patients. This disconnect afflicts both the intrinsic and instrumental wings of the argument. The claim that nonprofit hospitals as *institutions* are intrinsically worthy of being intimately trusted by patients does not capture patients' actual experiences of intimate exposure, which occur in relationship to *individual* caregivers. The notion that care-giving *persons* should possess sufficient virtue to merit the honor of being intimately trusted is

173. Across cultures and throughout history, normative writings on medical ethics have instructed physicians to aspire to high standards of virtue, not only in the clinic but also in their personal lives. Such writings frequently draw connections between a clinician's reputation for virtue, credibility in patients' eyes, and effectiveness as a healer. *E.g.*, Lucille F. Newman, *History of Medical Ethics: Primitive Societies*, *in* 2 ENCYCLOPEDIA OF BIOETHICS 877, 877-78 (Warren. T. Reich ed., 1978) (noting the relevance of belief in a doctor's power to heal in primitive medicine).

174. *See supra* notes 61-63 and accompanying text.

175. Wikler notes that medical practice at its current stage of development is ripe with possibilities for exploitation because it cannot be distilled down to "formulas and schedules that would more naturally be governed by contracts." Wikler, *supra* note 171, at 136-37. Rather, clinicians must continually make individualized, subjective judgments of a sort not susceptible to comprehensive prior specification.

intuitively appealing. However, the idea that *organizations*, as distinct from *individuals*, should or could be worthy in this way is more difficult to grasp. One might plausibly claim that organizational virtue can engender moral worthiness in individual caregivers, perhaps as a product of institutional culture or incentives. There are reasons for skepticism, however, about whether the nonprofit form accomplishes this in the hospital industry to a greater degree than does the for-profit organization form. There are no proven differences in the ways that nonprofit and for-profit hospitals pay or administer their clinical employees.[176] Nor are there evident differences in their economic or legal relationships with staff physicians who practice independently.[177] Nonprofit sector advocates commonly claim that differences exist in staff commitment to community, clinical excellence, or the needs of the poor,[178] but these claims remain undemonstrated.

Wikler's instrumental argument[179] suffers from the same failing. To the extent that patient trust is the product of individual staff members' clinical behavior, the nonprofit form's purported advantage in encouraging patient trust would have to arise from its influence on the character of individual caregivers. This influence is unproven and open to doubt. On the other hand, a measure of patient trust may flow from patients' generalized good feelings about an institution. If such feelings are more closely associated with the nonprofit form than with for-profits, Wikler's instrumental claim may thereby deserve some weight. However, to the extent that patients' positive feelings about the nonprofit form are rooted in assumptions about non-

176. Both nonprofit and for-profit hospitals employ their non-physician staff (nurses, laboratory technicians, dieticians, housekeepers, administrators, etc.) on a salaried basis. Both pay certain physicians, most typically pathologists and radiologists, on a salaried basis. Staff physicians, however, are more typically paid directly by patients and insurers. The principal exception is the HMO-operated hospital which, in both its nonprofit and for-profit variants, employs physicians on a salaried basis.

177. Although hospital influence on physician decision-making is clearly increasing, *see supra* text accompanying notes 100-05, for-profits have not appeared more aggressive than nonprofits in this regard. The emerging state common law governing hospitals' responsibility for the behavior of staff physicians makes no distinction between nonprofit and for-profit hospitals. Likewise, neither federal statutes and regulations nor the private accreditation process administered by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") impose different requirements on nonprofits and for-profits with respect to physician-hospital relations.

178. *See supra* note 32-36 and accompanying text.

179. *See* Wikler, *supra* note 171, at 137-38.

profit hospitals that do not square with institutional realities, such feelings cannot fairly be said to reflect institutional worthiness or virtue.

2. Virtue and the Exemption

The nonprofit hospital industry's claim to virtue, in short, is less than compelling. Yet the above analysis does not completely contravene the belief that nonprofit status retains some moral significance as a symbol of commitment to community and sensitivity to social and religious diversity. Indeed, the nonprofit form may retain residual potential to evoke patient trust, although that potential rests on popular assumptions that do not fully reflect market-driven reality. While the case for the moral superiority of nonprofit hospitals per se is weak, the nonprofit form may possess some symbolic virtues.

Whether these symbolic virtues justify per se income tax exemption cannot be determined in a purely utilitarian fashion, via a balancing of benefits and burdens, without doing injustice to the spirit of the virtue argument. Proponents of the virtue argument do not contend that the tally of exemption-related benefits outweighs the exemption's costs; they assert that the exemption represents a public affirmation of the nonprofit hospital's moral significance.[180] The exemption's utilitarian calculus, in their eyes, is beside the point.

Taking this argument on its own terms, there is good reason for skepticism. Monetary rewards for virtuous behavior do not obviously express moral significance. On the contrary, pecuniary rewards arguably undermine appreciation of virtue by inviting the perception that the things rewarded are being purchased for a price.[181] Indeed, in the early years of the charitable exemption, leaders of some charitable organizations took the position that tax subsidies encouraged "mercenary motives" and corroded private benevolence.[182] Moreover, the belief that these concerns are unfounded and that public money is apt recognition for privately-occurring virtue encounters a problem of limits. If

180. *See supra* notes 147-55 and accompanying text.

181. *Cf.* Margaret J. Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849, 1905-06 (1987) (contending that things that play an important part in our ideals about personhood cannot be exchanged for money without devaluing these ideals).

182. National Conference on Charities and Correction, *The Division of Work Between Public and Private Charities*, *in* PROCEEDINGS OF THE NATIONAL CONFERENCE ON CHARITIES AND CORRECTION 128-29 (1901), *quoted in* STEVENS, *supra* note 7, at 44.

such virtue by itself merits payment from the public fisc, how are we to determine whose virtues shall go unrewarded? Surely, many individuals (and even some for-profit firms) from time to time display virtues akin to those considered above. Why, then, restrict public rewards to nonprofit organizations?[183] The traditional virtue argument for tax exemption proves too much.

The virtue argument would be rendered more selective and thus more plausible were it to be recast in a narrower form. This could be accomplished by reconnecting the argument to its roots—the goodness of voluntaristic giving—and discarding its reliance on the symbolism just discussed, which has grown stale with the commercialization of the nonprofit hospital sector. To recognize voluntaristic giving, one might limit the availability of the exemption by tying it to actual donations of time and money. Instead of exempting all clinical activities, regardless of their sources of support, the IRS (or Congress) could fashion a fractional exemption, linked to the value of the voluntaristic contributions received by each hospital.[184] Such an approach would both preserve the deductibility of private gifts and exempt that fraction of each hospital's income traceable to the value of monetary gifts and volunteered labor.[185]

In its present form, however, the exemption cannot be justified by nonprofit hospitals' claims to virtue. Neither the questionable symbolic virtues reviewed in this section nor current levels of voluntaristic giving to nonprofit hospitals are persua-

183. One might answer this question with a rule-utilitarian response, for example, by arguing that the detection of virtue on a case-by-case basis is difficult and that nonprofit organizations are on the whole more likely to act virtuously than are individuals or for-profit firms. Given the reluctance of the virtue argument's proponents to make their case in consequentialist terms, this selective use of utilitarian reasoning would seem too clever by half.

184. *Cf.* Hall & Colombo, *supra* note 35, at 389-411 (proposing an income tax exemption limited to institutions receiving donations or "donative support," and designed to compensate for free rider effect's depression of donative behavior—a proposal derived from Burton Weisbrod's model of charitable giving as an inadequate response by supramedian demanders to the undersupply of a heterogeneously-desired public good).

185. The exempt portion of a hospital's net income could be calculated as follows: $EI = NI\ (VG + VL) / (TR + VG + VL)$, where EI = exempt income, NI = net income, VG = value of gifts, VL = value of donated labor, and TR = total revenues (e.g., reimbursement received from insurers, self-paying patients, or government entities that contract for care for the medically indigent) derived from the sale of services. The hospital's non-exempt income, or $NI - EI$, would be taxable. Supporters of this approach would need to work out many further details which go beyond the scope of this Article. For example, one would require methods to assign a value to voluntaristic labor, and to amortize the value of capital gifts over many fiscal years.

sive as a basis for the per se exemption's $4.5 billion annual claim on the public fisc.[186] Even if one eschews cost-benefit balancing as unresponsive to the metaphorical force of the virtue argument, the greater urgency of other claims on our public resources is difficult to resist. The moral force of myriad unmet social needs and the indecency of burdening future generations with the cost of today's unprecedented federal fiscal imbalance render the virtue argument almost embarrassingly weak by comparison.

III. THE EXEMPTION AS CARROT AND STICK

Over the past 10 years, the per se exemption of nonprofit hospitals has come under increasing attack from another quarter: public officials unhappy with private hospitals' indigent care performance. Scholarly portrayals of nonprofit hospitals as market-driven institutions[187] have been paralleled in journalistic accounts of hospital managers' efforts to avoid the provision of uncompensated care.[188] State and local officials caught between ballooning health care budgets and unsympathetic taxpayers have complained that private hospitals are not bearing their fair share of the indigent-care burden.[189] Critics of the

186. Multiple methodological problems preclude precise calculation of the exemption's cost to the Treasury, but this cost was recently estimated as follows: $1.7 billion in tax exempt debt, $1.6 billion in income tax, and $1.2 billion in deductible charitable contributions (totaling $4.5 billion). John Copeland & Gabriel Rudney, *Federal Tax Subsidies for Not-For-Profit Hospitals*, 46 TAX NOTES 1559, 1565 (1990). According to Copeland and Rudney, nonprofit hospitals accrue another $4.0 billion in benefits from their combined state and local tax exemptions (sales tax, $2.4 billion; property tax, $1.2 billion; income tax, $0.4 billion). *Id.*

187. *See, e.g.*, STEVENS, *supra* note 7, at 335-40 (identifying the business-oriented nature of nonprofit hospitals in the late twentieth century); Robert C. Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1416, 1417, 1473 (1980) (finding that nonprofit and for-profit hospitals do not differ relevantly in practice).

188. *See, e.g.*, Melinda Beck, *State of Emergency: Hospitals Are Seeking Radical Solutions to Ease Walk-in Patient Overload*, NEWSWEEK, Oct. 14, 1991, at 52 (reporting that emergency rooms, which are often the only health care available to indigents, are diverting people to community service centers); Tom Paulson, *Hospitals Face Day of Reckoning on Care of Poor*, SEATTLE POST-INTELLIGENCER, July 10, 1991, at A1; *see also* Michael Specter, *Emergency Rooms in Crisis; Overcrowding Said to Peril U.S. Health Care*, WASH. POST, Sept. 14, 1989, at A1 (describing overcrowded emergency rooms, and reasons for the shortage of beds and physicians).

189. *E.g., Hospital Charity Care and Tax Exempt Status, Restoring the Commitment and Fairness, Hearings Before the Select Comm. on Aging, House of Representatives*, 101st Cong., 2d Sess. 84-86, 88-90 (1990) (statement of Mary O. Boyle, Commissioner, Cuyahoga County, Ohio, and Chair, National Ass'n of

non-profit sector's indigent care performance identify three main failings: insufficient provision of charity care to the uninsured poor;[190] reluctance to treat Medicaid patients, for whom reimbursement rates typically fail to cover costs;[191] and inadequate provision of health promotion, clinical screening, education, and other outreach services to needy communities. These perceived failings, along with taxpayer antagonism toward new public spending, have inspired a search for legal means to make private hospitals do more for the poor without billing the government.[192]

Counties Taxation and Finance Subcommittee on Bonds, Representing the National Ass'n of Counties) (testifying to the concern shared by county governments, who are largely left with the burden of providing indigent health care, that private hospitals are not providing a significant share of charity care).

190. *See, e.g.*, GAO Report, *supra* note 51, at 34-35 (revealing private hospital's reluctance to expand poor people's access to care).

191. In 1989, according to American Hospital Association data, the Medicaid program's payments to hospitals covered 78% of Medicaid patients' costs nationwide. Medicaid payments equaled or exceeded patients' costs in only three states (Arizona, Maryland, and New Jersey). PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, OPTIONAL HOSPITAL PAYMENT RATES: CONGRESSIONAL REPORT 81 (1992) [hereinafter OPTIONAL RATES].

192. An earlier effort along these lines was notably unsuccessful. From the late 1940s through the early 1970s, the federally-funded Hill-Burton program awarded construction funds to nonprofit hospitals. *See* Hill-Burton Act, 42 U.S.C. § 291 (1988) (establishing federally-financed, state-administered program of grants, loans, and loan guarantees for hospital construction and modernization). Hospitals receiving aid under the Hill-Burton program were obliged to give assurances that they would provide a "reasonable volume of [uncompensated] services to persons unable to pay." 42 U.S.C. § 291c(e)(2) (1988).

Facilities that received Hill-Burton funds, however, often failed to honor these assurances. Lawrence A. Schneider, Comment, *Provision of Free Medical Services by Hill-Burton Hospitals*, 8 HARV. C.R.-C.L. L. REV. 351, 351-52 (1973). In 1974, after three decades of minimal enforcement, Congress authorized the Department of Health, Education, and Welfare (now the Department of Health and Human Services (HHS)) to promulgate regulations specifying Hill-Burton recipients' free and below-cost care obligations in financial terms. S. REP. No. 1285, 93d Cong., 2d Sess. 61 (1974), *reprinted in* 1974 U.S.C.C.A.N. 7842, 7900. The Department issued detailed regulations in 1979. 42 C.F.R. § 124.503(a) (1994). These requirements were upheld in American Hosp. Ass'n v. Schweiker, 721 F.2d 170 (7th Cir. 1983) (rejecting statutory and constitutional challenges brought by nonprofit hospitals' trade association), *cert. denied*, 466 U.S. 958 (1984). The 1979 regulations also require recipients to inform patients about the availability of uncompensated care, 42 C.F.R. § 124.504 (1994), oblige the HHS to investigate allegations of non-compliance by hospitals, *id.* § 124.511, and permit parties to seek judicial enforcement of free-care obligations if their complaints to the HHS are dismissed or not pursued, *id.* § 124.511(a)(4).

Efforts by advocates of the poor to make effective use of these regulations have not been successful. Despite ample evidence that violations remain widespread, *e.g.*, Kevin O'Neill, *Site Visits at 21 Hill-Burton Facilities Reveal Exten-*

Proposals to make tax exemption contingent upon the provision of free care and/or community services have been a product of this search.[193] State officials pioneered this strategy during the mid- and late-1980s,[194] challenging the property tax exemptions of nonprofit hospitals in state courts on the ground of failure to provide charity care.[195] Supported by a growing body of

---

sive Noncompliance, 16 CLEARINGHOUSE REV. 404, 404 (1982), agency enforcement activity has been minimal. *See* Michael A. Dowell, *Hill-Burton: The Unfulfilled Promise*, 12 J. HEALTH POL. POL'Y & L. 153, 153 (1987) (generally discussing Hill-Burton's impact upon poor people's access to care). *See also* National Health Law Program, *Hill-Burton, New Developments* (June 1987) (only 38 decisions by HHS in uncompensated care cases in 1986; hospitals won in 34 of these).

193. Another outgrowth of this effort has been the proliferation of federal and state legislation requiring private hospitals (both nonprofit and for-profit) with emergency departments to provide emergency care regardless of a patient's financial resources. At the federal level, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA 85") requires hospitals receiving payments under the Medicare program to treat any patient who has an "emergency medical condition which has not been stabilized" or is in "active labor," unless the patient (or a legally responsible person acting on that patient's behalf) has requested a transfer to another facility, or qualified hospital personnel have certified that a proposed transfer's medical benefits outweigh its risks. 42 U.S.C. § 1395dd(c)(1) (1988). An early assessment of COBRA 85 concluded that potential complainants' lack of knowledge about their rights and the paltry enforcement efforts by HHS were severely limiting the law's effect. HOUSE COMMITTEE ON GOVERNMENT OPERATIONS, EQUAL ACCESS TO HEALTH CARE: PATIENT DUMPING, H.R. REP. No. 531, 100th Cong., 2d Sess. 11 (1988). Many state legislatures also enacted laws in the 1980s barring the involuntary transfer or discharge of emergency patients because of their inability to pay. Geraldine Dallek & Judith Waxman, *"Patient Dumping": A Crisis in Emergency Medical Care for the Indigent*, 19 CLEARINGHOUSE REV. 1413, 1414-15 (1986).

194. John D. Colombo & Mark A. Hall, *The Future of Tax Exemption for Nonprofit Hospitals and Other Health Care Providers*, 2 HEALTH MATRIX 1, 1-2 (1992).

195. *Id.* In the pioneering case, Utah County v. Intermountain Health Care, Inc., 709 P.2d 265, 266-67 (Utah 1985), Utah's Supreme Court upheld the revocation of a nonprofit hospital chain's property-tax exemption. The court found that the state's charitable exemption was contingent on compliance with the requirement of an "element of gift" to the community. *Id.* at 272. The hospital's provision of only a negligible volume of uncompensated care did not meet this requirement. *Id.* at 274 (free and below-cost care provided by Intermountain during the period at issue was valued at less than one percent of the chain's gross revenues). Most courts have been more solicitous of nonprofit hospitals that provide minimal charity care. *See, e.g.*, Medical Ctr. Hosp. of Vt. v. City of Burlington, 566 A.2d 1352, 1355-57 (Vt. 1989) (nonprofit hospital not required to prove that it offered a certain amount of uncompensated care, but rather only that it had a policy of accepting all patients, regardless of their ability to pay); Downtown Hosp. Ass'n v. Tennessee State Bd. of Equalization, 760 S.W.2d 954, 955 (Tenn. Ct. App. 1988) (hospitals' charitable exemption not contingent upon provision of uncompensated services).

commentary urging such linkage,[196] Congress began in the 1990s to consider legislation that would condition the federal exemption upon compliance with minimum charity care and/or community benefit requirements.[197] Provisions to this effect were also part of several of the comprehensive health reform plans considered by Congress in 1994.[198]

I contend below that a credible case can be made for an exemption contingent upon the provision of minimum levels of free and under-compensated care to patients who cannot pay. This case gained strength in 1994 from the failure of President Clinton's campaign for universal health insurance. Indeed, I suggest that the case for such a conditional exemption can be made more powerfully (and pragmatically) than advocates for such an exemption have done thus far. Even so, I conclude that arguments for refashioning the exemption along such lines are ultimately unpersuasive on efficiency, equity, and other moral grounds.

I also argue that the case for conditioning the exemption upon community benefit criteria is unpersuasive. Not only does it encounter most of the same difficulties that beset use of the exemption as a tool to elicit free and undercompensated care, it poses distinct problems of definition and measurement, tied to the fact that market-driven activity itself yields social benefits.

A. Conditioning the Exemption Upon Charity Care

Since 1990, Congress has been weighing proposals to condition tax exemption of non-profit hospitals upon their provision of

196. *See, e.g.*, Simpson & Strum, *supra* note 4, at 633-34 (arguing for stricter tax exemption standards that would ensure that charitable hospitals provide sufficient community benefit); Thomas R. Barker, *Re-examining the 501(c)(3) Exemption of Hospitals as Charitable Organizations*, 48 Tax Notes 339, 350 (1990) (recommending that hospitals be required to devote "more than an insubstantial portion of their revenues to the provision of charity care" in order to qualify for tax exemption); GAO Report, *supra* note 51, at 44-45 (suggesting that the criteria for tax exemption could be "directly linked to a certain level of (1) care provided to Medicaid patients, (2) free care provided to the poor, or (3) efforts to improve the health status of underserved portions of the community"). *Cf.* Institute of Medicine Committee on Implications of For-Profit Enterprise in Health Care, For-Profit Enterprise in Health Care 193-94 (Bradford H. Gray ed., National Academy Press 1986) (urging "reasonable relationship" between a nonprofit hospital's volume of charitable contributions plus savings from tax exemption and its supply of "uncompensated service" in the form of charity care, institutionally-subsidized educational and research programs, and "unprofitable standby capacity").

197. *See infra* note 199.

198. *See infra* note 200.

minimum levels of charity care.[199] In 1991, two such bills were introduced in the House of Representatives,[200] prompting alarm among nonprofit hospital managers.[201] Neither bill reached the House floor, and by 1992, argument over the contours of the charitable exemption had become subsumed within the larger debate over health care financing reform. None of the health care reform proposals considered by Congress in 1993 contained language conditioning the exemption upon the provision of free and undercompensated care. In the summer of 1994, however, the House Ways and Means Committee reported a bill that set forth a variety of free and undercompensated care obligations, including the requirement that an entity claiming exemption provide "medically necessary" care "to the extent of its financial ability" without discrimination based upon ability to pay.[202] This language survived in the subsequent, ultimately unsuccessful, bill introduced by House Majority Leader Richard Gephardt.[203]

---

199. Terese Hudson, *Congress Measures Hospitals' Community Benefit*, HOSPITALS, Oct. 20, 1990, at 34.

200. Both bills would have conditioned nonprofit hospitals' federal tax exemption upon their compliance with minimum uncompensated care and community service standards. *See generally* The Charity Care and Hospital Tax-Exempt Status Reform Act of 1991, H.R. 790, 102d Cong., 1st Sess. (1991) [hereinafter Roybal 91] (introduced by Rep. Roybal and amending the "Internal Revenue Code of 1986 to require tax exempt hospitals to provide sufficient charity care and community benefits"); H.R. 1374, 102d Cong., 1st Sess. (1991) [hereinafter Donnelly 91] (introduced by Rep. Donnelly and amending the Internal Revenue Code of 1986 "to clarify the requirement that hospitals provide certain emergency medical care in order to be exempt from income tax, and for other purposes"). For a comprehensive discussion of these proposals, see Colombo & Hall, *supra* note 194, at 10-28. The Bush administration opposed the minimum uncompensated care and community benefit standards contained in these bills. Treasury Statement, *supra* note 32, at 35-36.

201. *See* Edward A. Kazemek & Michael W. Peregrine, *Guarding Tax-Exempt Status Amid Legislative Scrutiny*, HEALTHCARE FIN. MGMT., May 1991, at 16 (warning that "momentum is gathering behind legislation restricting Federal tax exemption" and urging health care managers to mobilize against such proposals).

202. H.R. REP. No. 601, 103d Cong., 2d Sess., pt. 1, at 314 (1994). The House Ways and Means Committee bill also decreed that exempt health care organizations must not discriminate on the basis of ability to pay when providing emergency services. *Id.* In addition, the bill required exempt organizations not operating in "medically underserved" areas to provide "outreach" services at below-cost prices to persons otherwise unable to afford them. *Id.* The bill also obliged exempt organizations not to discriminate against patients insured by government-sponsored programs such as Medicaid (which tends to compensate hospitals for less than their average costs). *Id.*

203. 140 CONG. REC. H7509, H7706 (daily ed. Aug. 10, 1994) (Amendment to House Bill 3600 offered by Rep. Gephardt). The Senate Finance Committee re-

1. Hospitals as Charities

Beyond the political attractiveness of free-care requirements as a way to shift medical costs away from publicly-funded institutions,[204] the imagery of charity has moral force. Private benevolence has always held a special place in American life, both as an affirmation of human connectedness within communities and as a less intrusive alternative to state intervention on behalf of the needy.[205] More recently, the "reprivatization" of America's social obligations has come into vogue[206] as a response to public sector rigidities. Even among those who hold that government has a duty to ensure universal access to health care, private charity is commonly regarded as a desirable element in national efforts to achieve such access.[207] That tax exemption should reward private benevolence in response to the

---

ported a bill that preserved some of the House Ways and Means Committee's requirements. S. 2351, 103d Cong., 2d Sess. (1994). Notably absent were the Ways and Means provisions requiring hospitals to provide medical care "to the extent of [their] financial ability," and requiring those organizations not operating in "medically underserved" areas to provide "outreach" services to the poor at below-cost. *See supra* note 202 and accompanying text. Senator Mitchell incorporated the Finance Committee's approach to the exemption into his subsequent, ill-fated health care reform proposal. S. 2357, 103d Cong., 2d Sess. (1994).

204. Local governments finance health care for the poor through a variety of mechanisms, including contractual arrangements with private hospitals and the operation of public facilities. Cost-shifting aspirations sometimes surface openly in debate over proposals to condition the exemption upon provision of free care. *See, e.g.*, 137 CONG. REC. 42, E896 (statement of Rep. Donnelly) (urging free care requirements as a means of reducing the indigent care burden on public hospitals). Medicaid is the primary medical cost burden for state governments. During the late 1980s and early 1990s, economic recession, federally-mandated expansions in Medicaid eligibility, and continuing health care cost inflation combined to force large annual increases in states' Medicaid expenditures. John K. Iglehart, *The American Health Care System: Medicaid*, 328 NEW ENG. J. MED. 896, 898 (1993). After rising at an annual rate of about 10% through most of the 1980s, nationwide Medicaid spending jumped 13% in 1989, 19% in 1990, 32% in 1991, and an estimated 31% in 1992. *Id.* Between 1988 and 1992, Medicaid spending grew at an annual compound rate of 21.6%. *Id.* at 897. In 1992, Medicaid cost the states an estimated $48.6 billion. *Id.* at 898.

205. *See* STEVENS, *supra* note 28, at 41 (affirming the historical importance of private benevolence).

206. Uwe E. Reinhardt, *Uncompensated Hospital Care*, *in* UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 1, 4 (Frank A. Sloan et al. eds., 1986).

207. *See, e.g.*, PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE 29-30 (1983) (characterizing charity as "important" but inadequate part of society's efforts to achieve universal access to care) [hereinafter SECURING ACCESS].

medical needs of the poor has seemed a natural corollary for some, whether as a matter of financial quid pro quo or symbolic moral recognition.

Yet the imagery of charity rings hollow when it comes to hospitals. Most obviously, the free care provided by nonprofit hospitals is financed largely by private payers,[208] who are hardly inspired by donative benevolence. The system of cross-subsidies that supports each hospital's free and below-cost care is a product of that hospital's differential market power over its various payers. Payers that control large proportions of patients within a geographical area are able to exercise monopsony power in their dealings with hospitals.[209] As a result, the rates they pay often fall below their patients' average costs.[210] To the extent that these monopsonistic buyers fail to cover their average costs, hospitals must (at least in the short run)[211] look to other payers to make up the difference. Hospitals do so by extracting much higher payments for the same services from insurers with little or no market power. Such payers tolerate discriminatory pricing to preserve their access to hospitals over which they lack monopsony power. To the extent that subscribers value this access, such insurers are under market pressure to maintain it. Not only do these payers thereby subsidize monopsonistic private purchasers, they also finance both free

208. *See supra* text accompanying notes 39-40.

209. Among private payers, managed-care providers (Health Maintenance Organizations and Preferred Provider Organizations) are generally in the best position to wield such market power, by channeling their subscribers to a small number of hospitals. In 1990, according to the Health Insurance Association of America, 59% of conventional insurers paid undiscounted charges to hospitals, while only 15% of HMOs and 21% of PPOs did the same. OPTIONAL RATES, *supra* note 191, at 41. Among the discounting methods commonly employed by managed-care organizations are diagnosis-based and capitated payment, per-diem rates, and discounted charge-per-service payment. *Id.*

210. *See* Charles E. Phelps, *Cross-Subsidies and Charge-Shifting in American Hospitals*, *in* UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 108, 110, 116-19 (Frank A. Sloan et al. eds., 1986) (discussing relationships between payers' monopsony power and cross-subsidization of common costs).

211. Over the longer term, hospitals might in theory choose to reduce their average costs (e.g., by cutting back on new capital investment) or decline to renew their contracts with hard-bargaining monopsonists. Either course carries risks; reduced investment could diminish a hospital's attractiveness to patients (and to referring physicians), while refusal to contract with large purchasers shrinks a hospital's pool of potential patients.

care and services to patients covered by below-cost public payers[212] (Medicaid and Medicare).[213]

In 1992, private payers paid an estimated 38% more on average than their patients' costs, up from 25% in 1989.[214] By 1992, cross-subsidies from private payers were financing 14% of American hospital costs, up from 11% in 1989.[215] Uncompensated care, defined as bad debt plus charity care less government subsidies to the poor, accounted for $11.9 billion of this cost-shift in 1992.[216] Another $22.7 billion in cross-subsidies financed the difference between costs and payments for government-sponsored programs, principally Medicare and Medicaid.[217]

This remarkable pattern of cost-shifting is the product of the evolving balance of market power between hospitals and private payers. It is not the product of payers' donative inclinations. On the contrary, payers are under increasing pressure to resist rising hospital costs while maintaining the confidence of subscribers. Many payers are attempting to do so by concentrating their buying power on small numbers of hospitals so as to avoid getting hit by large cost-shifts (and, if possible, to negotiate prices that fall below their *own patients'* average costs). Indeed, much of the appeal of managed-care systems derives from their ability to target the purchasing power of large groups to-

212. *See* Phelps, *supra* note 210, at 112-16 (discussing hospital managers' decisions about the use of excess revenues generated through the exercise of monopoly power).

213. In 1990, according to American Hospital Association data, Medicaid and Medicare reimbursed hospitals at aggregate rates of 80.1% and 89.6% of costs, respectively. OPTIONAL RATES, *supra* note 191, at 40.

214. LEWIN-ICF, COST-SHIFTING: A SELF-LIMITING PROCESS 12 (1992) [hereinafter COST-SHIFTING] (reporting estimates based on American Hospital Ass'n data). Payment-to-cost ratios vary remarkably, by payer and by employer group. According to a 1990 survey of 58 large employers (with more than 4000 employees), employer-specific payment-to-cost ratios ranged from 89% to 168%. Aggregated by decile, employers' payment-to-cost ratios varied from 116% to 153%. OPTIONAL RATES, *supra* note 191, at 91.

215. COST-SHIFTING, *supra* note 214, at 8.

216. The comparable figure in 1989 was $8.9 billion. *Id.* In 1990, according to American Hospital Association data, operating subsidies from state and local governments covered only 21% of hospitals' uncompensated-care costs. OPTIONAL RATES, *supra* note 191, at 40.

217. COST-SHIFTING, *supra* note 214, at 7-8. Of this $22.7 billion, $14.4 billion covered the Medicare program's cost-to-payment gap and $8.1 billion made up the difference for Medicaid patients. These figures were up from $6.9 billion and $4.2 billion respectively in 1989. *Id.*

ward a relatively small number of providers.[218] The growing ability of health care payers to resist cost-shifting is causing concern among hospital managers, who, with good reason, fear a breakdown in their ability to finance undercompensated care.[219] From the perspective of payers, however, cross-subsidization constitutes a tax imposed on those buyers with the least bargaining power to cover others' costs.[220]

One might object to this benevolence-denying portrayal of the financing of free and undercompensated care on the ground that it disregards the role of hospitals as charitable actors. Even if excessive payments are extracted from health care buyers by means of raw market power, do not hospitals merit recognition as charitable agents for *choosing* to spend this money on free and undercompensated services? Characterizing cross-subsidies as akin to *taxes*, which are collected and disbursed by entities acting as *governments*,[221] denies the charitable agency of hospitals. Focusing on payers, as opposed to hospitals, as putative charitable agents, is inconsistent with the public's inclination to view myriad other commercial sellers as charitable actors. Gifts from corporations are widely considered charitable[222] even though the wealth that finances them was accumulated in the marketplace. Indeed, all philanthropic actors derive their funding from paying customers, from whom charitable donors are never more than a few transactions removed.[223] Any charity-

218. *See supra* note 209 (noting that managed-care providers often wield monopsony power over hospitals).

219. COST-SHIFTING, *supra* note 214, at 15.

220. *See* Clark, *supra* note 187, at 1468 (criticizing hospital cross-subsidies as taxes levied by private entities acting as non-democratic "minigovernments").

221. *See, e.g.*, COST-SHIFTING, *supra* note 214, at 14 (concluding that hospitals serve as "quasi-governmental bodies, imposing taxes on one set of patients to cover the unreimbursed costs of another").

222. *See, e.g.*, Marian Courtney, *A Company with a Social Conscience*, N.Y. TIMES, Mar. 6, 1994, § 13, at 1 (reporting on the Ben & Jerry's Ice Cream Co. charitable giving program); Lisa Klug, *Bagels Build Better World*, S.F. EXAMINER, Dec. 23, 1994, at B1 (reporting on bakery chain's annual community grant program); Pamela Marin, *350 Make Room for Ronald*, L.A. TIMES, Jan. 21, 1988, § 9, at 4 (reporting favorably on Ronald McDonald Children's Charities which provide low-cost, temporary housing for families of seriously ill children).

223. Like hospitals, most institutional and individual donors contribute funds which are acquired directly from goods, services, or capital markets. Other charitable givers are more than one transaction removed from paying customers. Examples include the United Way and other entities that receive gifts from firms and individuals (who themselves accumulate resources via market transactions) and in turn disburse these aggregated contributions to other charitable recipients.

giving entity that derives its revenues from commercial transactions and exercises market power can be alternatively characterized as an entity that imposes "taxes" on some people to finance expenditures by others.

As regards hospitals and other commercial entities that give away goods and services, the choice between these two portrayals is a matter of perspective. What seems charitable to such a donor (and its recipients) may seem more like a commandeering of private resources from the veiwpoint of the purchasers who foot the donor's bills. There may be no Archimedean answer to this question of characterization, but the enormity of hospital cost-shifting weighs in favor of the hospital payers' perspective. Were large numbers of privately-insured Americans to realize that their insurers "reimburse" the hospital industry for at least a third more than their patients' costs,[224] the "tax" metaphor would probably appeal more widely than the imagery of "charity." It seems unlikely that a similarly large mark-up by the local power company would be widely seen in terms of charity, even if the proceeds went toward service for the poor. Quite apart from the question of whether such a cross-subsidy is socially desirable, its cost to individual rate-payers seems more evocative of state coercion than of private generosity.[225]

2. Beyond the Imagery of Charity: Cross-Subsidies, Compassion, and the Politics of Disingenuity

Although portraying nonprofit hospitals as charities may be unpersuasive, a case may arguably be made for refashioning the charitable exemption to elicit additional free and below-cost care for the poor. Such a case would need to build on the merits of additional cross-subsidization from private payers to finance

224. *See supra* text accompanying notes 124-34 (describing the overcapitalization of the nonprofit hospital industry as third-party payers shield ignorant patients from the actual costs of medical services).

225. How we choose between the narratives of "charity" and "taxation" in characterizing such arrangements is a question beyond the scope of this Article. I suspect this question may be tied to the more general problem of distinguishing between autonomous and coerced actions. I suggest that such distinctions rest on poorly visible judgments about the desirability of the arrangements at issue. *See* M. Gregg Bloche, *Clinical Counseling and the Problem of Autonomy-Negating Influence*, *in* HIV, AIDS, AND CHILDBEARING: PUBLIC POLICY, PRIVATE LIVES (R. Faden & N. Kass eds., forthcoming 1996). One might, for example, be more inclined to see a particular cost-shift as a "tax" (evoking the imagery of state coercion) if it seems normatively troubling for some reason, and more inclined to view it as "charity" (suggesting the imagery of autonomous action) if it seems desirable.

free and below-cost care. An argument to this effect can be made more plausibly than the advocates for conditioning tax exemption upon the provision of free care have done thus far.[226] I will begin with the fiscal basis for this line of argument—the link between conditioning exemption on free and below-cost care and hospital decision-making about the levels of such care.

a. *Conditional Exemption and Cross-Subsidization Levels*

Like any tax benefit, exemption of nonprofit hospitals constitutes a subsidy for some set of activities. Proponents of a free-care requirement often represent the exemption as payment from the state for care given to the poor. Whatever the merits of this portrayal as justification for a tax subsidy, the exemption presently functions in practice as a more general subsidy for hospital services. For a generation or more, hospital managers, pricing, investment, and other financial matters have taken account of a federal tax subsidy that is available virtually without restriction.[227] If the exemption suddenly became contingent upon the provision of free or undercompensated care, further cross-subsidization from private payers would be necessary to finance any *additional* such services necessary for a hospital to qualify. In theory, one might argue, such services would arguably be paid for by the hospital's tax subsidy, which would no longer be available to management as an unrestricted windfall. But the immediate, practical effect of a shift from per se exemption to free and below-cost care requirements would be an additional levy on many private payers.[228]

The impact of such a shift would undoubtedly be felt unevenly by differently-situated nonprofit hospitals and payers. Minimum free and below-cost care requirements imposed by Congress or the IRS would almost certainly fall below the levels of such care that some hospitals now provide. Urban facilities in

226. A parallel argument for conditioning exemption on the provision of community services is discussed below. *See infra* text accompanying notes 312-27.

227. *See supra* text accompanying notes 22-31.

228. Although I characterize this levy here as an additional cost-shift to private payers, one might alternatively conceptualize it as a price increase that is appropriately reflective of the elimination of an across-the-board hospital subsidy, with the implementation of a targeted subsidy in its place. Seen in these latter terms, such a price increase would pay for hospital costs incurred by subscribers, as opposed to additional free or undercompensated care. On the other hand, the fact that the current exemption's across-the-board subsidy is part of the settled expectations of health care payers and hospital managers makes the former characterization more realistic.

neighborhoods with large numbers of uninsured and Medicaid patients are paradigmatic examples. These and other high-volume free and below-cost care providers could retain their exemptions without increasing their spending on such care. Private payers, in turn, would not be asked by these facilities to bear larger cost-shifts as a consequence of the conversion from per se to conditional exemption.[229]

On the other hand, hospitals that provide insufficient free and below-cost care to qualify for conditional exemption would confront a choice between increasing their levels of such care and losing their exemptions.[230] Facilities that derive greater financial value from exemption than the cost of the additional free and below-cost care needed to qualify could be expected to increase their provision of such services to attain the necessary volume. The additional cost-shift entailed would, in turn, devolve upon private payers.[231] Even if the financial benefit a hospital derives from exemption is less than the cost of the additional free and below-cost care needed to qualify, fear of the reputation consequences of the loss of exemption could prompt hospital managers to provide the additional services, and shift the cost to private payers.[232] Some hospitals, however, may nevertheless forego exemption rather than offer the added free and below-cost care necessary to maintain it. Such hospitals would most likely try to pass the cost of the loss of exemption to their payers, pushing health insurance prices slightly upwards.

b. *The Political Failure of Explicit Subsidies*

For the reasons just discussed, the case for conditional exemption as a tool for eliciting free and below-cost care for the

229. Indeed, if neighboring hospitals were to respond to this conversion by increasing their provision of free or below-cost care, *see infra* text accompanying notes 245-48, some high-volume providers might experience decreases in community demand for such care. In turn, some payers would be able to see reductions in the cost-shifting burdens that these providers ask them to bear.

230. This assumes an IRS enforcement program effective enough to dissuade hospital managers from betting on the prospect that failure to comply with free and below-cost care requirements would go undetected.

231. This assumes that the hospitals involved possess enough market power to impose this additional cost-shift.

232. The additional cross-subsidization engendered by free and below-cost care requirements would burden different private payers to disparate degrees, due to varying balances of market power between hospitals and payers. Analysis of the distribution of this additional cost-shift across differently-situated payers is beyond the scope of this Article. In general, however, one might expect this burden to fall disproportionately upon those payers with the least monopsony power.

poor is inseparable from the merits of cross-subsidization. Absent the imagery of charity, an argument can be made for promoting cross-subsidization from private payers to finance care for the poor. Intrinsic in this argument is the persisting tension between American's commitment to market mechanisms for allocating resources to health care, and its aspirations for egalitarian distributional results.[233] This tension was dramatically illustrated in 1994, when aspirations for universal coverage foundered on congressional reluctance to require either individual taxpayers or employers to pay for broadened coverage.[234] Such reluctance has repeatedly stymied efforts to institute explicit, direct public financing for medical care for the currently uninsured.[235] Put delicately, public dissatisfaction with medical market outcomes has thus far been insufficient to bring about the mandatory redistribution needed to greatly expand access to health care. Put less charitably, Americans of means have proven unwilling to ante up in support of their professed desire for universal health care. Yet, even outspoken opponents of expanded public financing blanche at the prospect of people going without care for serious medical problems.[236]

---

233. In Uwe Reinhardt's words, "[a] uniquely American phenomenon . . . has been the endeavor to extract an *egalitarian* distribution of health care from a delivery system still firmly grounded in *libertarian* principles." Reinhardt, *supra* note 206, at 8 (emphasis added). As Reinhardt observes, the pursuit of more or less egalitarian distributions of health care is common among industrialized nations, but the American degree of insistence upon free market principles is singular. *Id.* at 8-9.

234. Virtually all participants in the 1994 congressional debate acknowledged that some such requirement was necessary to achieve universal coverage. Opponents of the so-called "employer mandate" took the position that universal coverage was not an affordable goal. Adam Clymer et al., *The Health Care Debate: What Went Wrong? How the Health Care Campaign Collapsed—A Special Report*, N.Y. TIMES, Aug. 29, 1994, at A1.

235. Even Medicaid, the nation's largest-scale public initiative to pay for medical services for the poor, evinces this reluctance. State and federal legislators have failed to fund the program sufficiently to cover its beneficiaries' full inpatient costs, *see supra* notes 216-17 and accompanying text, and its eligibility requirements exclude more than half of all Americans with incomes below the poverty line. Iglehart, *supra* note 204, at 897. *See also Issues Relating to Managed Care: Hearings Before the Subcommittee on Health of the House Committee on Ways and Means*, 103d Cong., 2d Sess. 388 (1994) (statement of Diane Rowland, Executive Director, Kaiser Commission on the Future of Medicaid).

236. *See CNN News: Rep. Newt Gingrich Takes Calls on Health Care Reform* (CNN television broadcast, Aug. 8, 1994) (transcript on file with CNN) (then-House Minority Whip Newt Gingrich declared, "If you're in a car wreck or if you're in a situation where you have a sudden crisis, even if you don't have insurance, we've got to make sure you get health care."); *Larry King Live: Bob Dole to Pres. Clinton—'Let's Make a Deal'* (CNN television broadcast, Sept. 23, 1993) (transcript on file with CNN) (then-Senate Minority Leader Robert Dole

Cross-subsidization from private payers is easy to criticize as a disingenuous product of the failure of our political will. As Uwe Reinhardt explained, this type of "cost-shifting . . . has actually served as a fig leaf of sorts over a rather unseemly part of the American body politic: its inability thus far to fold every American into at least a catastrophic health insurance program."[237] This unseemliness is, perhaps, more prominent in the wake of our most recent failure in 1994. Nevertheless, the politics of conferring public subsidies is commonly obscurantist, even deceptive. Political visibility may further the ends of efficiency and moral honesty, but at the same time, invite resistance from those asked to bear the cost.[238] This resistance is especially likely to hinder efforts to provide subsidies for services typically distributed via the marketplace. To a large degree, the ingenuity of would-be architects of health care financing reform in the 1990s has focused on the crafting of institutional arrangements that steer artfully around such resistance.[239] Notably, within the past few years, there has been a widening disconnect between the academic search for efficiency or justice in institutional design and the political quest for a reform scheme able to garner a legislative majority.[240]

---

insisted, "You may not be covered, but you can't be turned away. You can always get care in America."). Put in economic terms, the perception of universal access to essential, crisis-oriented medical care produces such large positive externalities (good feelings derived from the belief that all in need of such care are receiving it, *see supra* note 49) that virtually no public official can afford to openly countenance the denial of such care.

237. Reinhardt, *supra* note 206, at 4.

238. *See* Peter H. Schuck, *Designing Hospital Care Subsidies for the Poor, in* UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES 72, 80-83 (Frank A. Sloan et al. eds., 1986) (contending that the politically preferable level of visibility for subsidies is a function of public officials' need to obtain credit from beneficiaries while disarming or even misleading cost-bearers).

239. The chief architects of President Clinton's health reform plan acknowledge that this political challenge inspired their design. *See, e.g.*, Paul Starr & Walter A. Zelman, *A Bridge to Compromise: Competition Under a Budget*, HEALTH AFFAIRS, Supplement 1993, at 7, 8-9 (asserting that their model, based on managed competition, purchasing cooperatives and employers, and global budgeting, offers a decent compromise that would achieve both the federal goal of universal coverage and the public's goal of cost containment); *see also* Lawrence D. Brown, *Who Shall Pay? Politics, Money, and Health Care Reform*, HEALTH AFF., Spring (II) 1994, at 175 (evaluating Clinton proposal and other financing strategies with respect to their ability to survive antagonism from those who would pay).

240. The political fate of Alain Enthoven's "managed competition" model is a case in point. Although managed competition has recently been the centerpiece of numerous proposals for achieving universal coverage and cost control, no bill introduced in Congress has contained all of the elements that Enthoven argues

c. *The Political Allure of Cross-Subsidization*

Unlike mandatory employer contributions, the single-payer model, or other financing schemes advocated by proponents of universal coverage, the shifting of costs to private payers has proven politically viable on a national scale.[241] Several factors have favored this success, and they invite expanded reliance upon cross-subsidization in the future. Indeed, cross-subsidization is in some ways uniquely suited to the American tension between commitment to market mechanisms and aspirations for a measure of equity, or at least basic decency, in the distribution of medical care.

Most obviously, cost-shifting occurs apart from public budgets. Government actions that mandate or encourage cost-shifting—requiring hospitals to provide emergency care to patients who are unable to pay, or by conditioning tax exemption upon the provision of free services—risk incurring the wrath of hostile taxpayers. To be sure, there are limits to the political viability of such off-the-budget levies on private resources. For example, the so-called "employer mandate," which appealed to its advocates as an off-the-books alternative to a payroll tax,[242] foundered politically in the face of resistance from those being asked to pay.[243] By contrast, the consumers and employers who

---

are essential to making managed competition work. In particular, mandatory employer contributions and an end to the tax deductibility of insurance premiums in excess of those charged for some benchmark plan, have encountered prohibitive opposition. Enthoven & Kronick, *supra* note 99, at 95-96.

Another example is a concession by two of the principal designers of President Clinton's proposal that their scheme may make more political than economic sense:

> Reform will meet fewer objections if its financing resembles the current, employer-based system of insurance premiums. A tax-based system might well be simpler, more efficient, and more progressive. Nevertheless, converting to a tax-financed system inevitably would create large numbers of losers as well as winners—and the losers would be affluent and powerful. Health care reform is hard enough without stirring upper-income taxpayers to opposition.

Starr & Zelman, *supra* note 239, at 16.

241. *See supra* notes 192-94 and accompanying text (discussing Hill-Burton free-care regulations, federal and state emergency-care requirements, and charity requirements for state property tax exemption).

242. *See generally* Adam Clymer, *Health Legislation Advances in Senate*, N.Y. TIMES, June 10, 1994, at A1 (reporting on three alternative health care reform proposals for employer mandates).

243. *See, e.g.*, Michael Weisskopf, *Delivering a Defeat for Total Coverage*, WASH. POST, July 19, 1994, at A6 (describing Rep. John D. Dingell's, chairman of the U.S. House Energy and Commerce Committee, battle for employer mandates and the reasons for defeat). The consensus expectation among economists is that firms burdened by an employer mandate will, in general, pass the man-

bear the burden of hospital cost-shifting have been remarkably tolerant of the public policies that promote it. This tolerance, in the face of an aggregate cost-shift that now exceeds one third of the expenses incurred by privately-insured patients,[244] is consistent with the tenet that political resistance to redistribution is path-dependent. All else being equal, redistributive channels that run through the government seem more likely to inspire opposition than pathways cut exclusively through private terrain.

The political success of cost-shifting is also a function of its stealth qualities as a redistributive channel though the private domain. In contrast to the employer mandate, which compels a highly visible flow of resources from businesses to their workers,[245] policies that encourage cost-shifting engender more submerged and diffuse movements of resources, mediated by market transactions and much-decentralized administrative discretion. The flow of monies in excess of average cost from consumers (and employers) to hospitals that provide free or below-cost care is a product of bargaining between each hospital and its payers. Multiple contests of market power between seller and buyer thus determine the resources available to each hospital for free and undercompensated services. Not only does the marketplace thereby diffuse responsibility for the collection of cross-subsidy dollars, it also lends a patina of capitalist legitimacy to hospital cost-shifting, arising from the premise that those who accumulate wealth through the market have broad discretion to dispose of that wealth as they see fit. The fact that hospital managers' exercise of this discretion is much decentralized, in comparison with resource allocation done on a national

---

date's cost to employees in the form of lower wages. If pre-mandate wages are sufficiently high so that passing the mandate's costs to employees reduces wages to levels *above* the federal minimum wage, then such a mandate will not (ignoring adjustment effects) increase employer costs. By contrast, if pre-mandate wages are so close to the federal minimum that a complete pass-through of the mandate's cost to workers would reduce wages to levels *below* the federal minimum, then such a mandate will increase employer costs (since a complete pass-through would be illegal). *See generally* Vic Ocstrowidzki, *Opposition Grows to Employer-paid Health Care Plan: Critics Denounce Program as New Tax, a Job Destroyer*, SAN FRANCISCO EXAMINER, Dec. 20, 1993, at A9 (discussing the reasons for the increasing unpopularity of the employer mandate proposal).

244. *See supra* text accompanying note 224.

245. Less easily traceable (for non-economists, at least) is the "backflow" of resources—from employees to firms in the form of compensatory wage reductions—created by employer mandates. *See supra* note 243 (explaining how an employer mandate will affect wage levels).

or regional level, adds to the political appeal of cross-subsidization as a low-profile redistributive technique. Decisions about the use of payments in excess of average cost—such as whether to spend on free care, community outreach services, or new technology—are made by administrators at each hospital, not some central authority.[246]

The low visibility of hospital cost-shifting may suffice to explain the political viability of public policies that encourage or require it.[247] However, health care payers are hardly ignorant about cost-shifting. Increasingly on the lookout for ways to contain costs, insurance companies and large, self-insuring employers are eyeing cross-subsidization as an avoidable expense. Indeed, concern about cost-shifting has spurred some employers and insurers toward support for federal measures to achieve universal health coverage.[248] Though perhaps poorly visible to the general public (and to small employers without expertise in health care markets), cross-subsidization is now well-known to sophisticated health care buyers.[249]

Yet this knowledge has not thus far translated into vigorous political resistance by private payers toward existing public policies that promote cost-shifting. An explanation probably lies in the collective action problems that beset such resistance. The individuals and firms that bear the burden of cost-shifting are distributed across diverse realms of American economic life. Unlike individuals or firms in a particular trade or industry, the nation's health care payers do not belong to one or a few organizations designed to marshall collective resources in the pursuit of shared political ends.[250] This lack of cohesion translates into

246. Some multi-hospital systems may represent exceptions, at least to the extent that system-wide managers constrain the discretion of each facility's administrators in this sphere.

247. Peter Schuck presents the concealment of subsidies as a critical requisite for their political success, particularly when subsidies are channeled to the poor. Schuck interprets much about the design of subsidies in terms of how alternative collection and distribution mechanisms obscure subsidy creation and growth. Schuck, *supra* note 238, at 77-78, 80-83.

248. Kip Sullivan, *Employers Should Join Debate Over Health Care Reform*, MINNEAPOLIS STAR TRIB., Mar. 8, 1993, at D3.

249. See RICHARD J. ARNOULD ET. AL, COMPETITIVE APPROACHES TO HEALTH CARE REFORM 1-6 (1993) (explaining how health care providers often cut cross-subsidy charges to compete for large purchasers).

250. To an increasing degree, large employers represent an exception to the lack of political cohesion among health care payers. Organizations such as the National Association of Manufacturers and the U.S. Chamber of Commerce have begun to articulate the cost-related concerns of large health care payers. These concerns add a new ingredient to the previously provider- and insurer-

political weakness in the face of support for cost-shifting by such better-organized interests as state and local governments.[251]

Moreover, the availability of market alternatives reduces individual payers' incentives toward creating new structures for collective political resistance to cost-shifting. A health care buyer can reduce or avoid its cost-shifting burden by taking contractual steps to obtain the monopsonistic upper hand in its dealings with hospitals. Large employers can accomplish this with relative ease, by concentrating their buying power on a small number of hospitals.[252] Smaller employers can achieve similar results by enrolling their work forces in health plans that themselves exercise monopsony power in their dealings with hospitals. The creation of privately-operated and government-sponsored health care purchasing cooperatives in some localities[253] offers even the smallest of businesses (as well as individual consumers) contractual access to the buying power of

---

dominated politics of health care financing. *See, e.g.*, Spencer Rich & Ann Devroy, *Chamber of Commerce Opposes Clinton Health Plan*, WASH. POST, Feb. 4, 1994, at A12 (reporting on refusals by the National Association of Manufacturers, the U.S. Chamber of Commerce, and the Business Roundtable to support the Clinton Administration's health reform plan because of fears about its cost).

251. Similar collective-action problems discourage opposition by health care payers against vigorous government enforcement of policies that promote cost-shifting. With respect to the formulation of enforcement policy, the problems are virtually the same. With respect to the exercise of case-by-case discretion by enforcement agencies, a different problem arises: individual payers (especially the largest and most powerful among them) tend to have relatively small stakes in the outcome of an enforcement action against a particular hospital, since payers generally cover services at multiple hospitals and since hospitals typically derive revenues from multiple payers.

252. They can contain costs in a number of ways, for example, by creating their own managed health plans or by channeling employees into existing plans that use only a small number of hospitals.

253. By the summer of 1994, 20 states had enacted legislation promoting publicly or privately-sponsored health care purchasing cooperatives. Milt Freudenheim, *The Health Care Debate: Purchasing Cooperatives*, N.Y. TIMES, Aug. 17, 1994, at A16. *See also* Lynn Wagner, *GAO Study Contradicts Buying Cooperatives' Image in Reform Debate*, MODERN HEALTHCARE, June 27, 1994, at 84 (discussing a General Accounting Office study of private and public purchasing cooperatives in California, Florida, Minnesota, Ohio, Washington, and Wisconsin); Mike Oliver, *Cooperative Makes Way for Alliance: Florida Health Access Weans off Clients*, ORLANDO SENTINEL, July 4, 1994, at B13 (discussing Florida's move from a state-wide government-sponsored purchasing cooperative to voluntary and privately-organized purchasing alliances as part of the state's health care reform); Rogers Worthington, *Health Pools Lure Insurance Agents*, CHICAGO TRIB., Mar. 31, 1994, at N4 (discussing a private purchasing alliance created by insurance agents in Iowa, and the skepticism surrounding its ability to promote consumer interests and health care reform).

large plans. As a rule, it would appear, individual health care buyers can more efficiently resist cost-shifting via non-cooperative, contractual mechanisms than through collective political opposition.

Cross-subsidization, in short, has singular political advantages as a means of financing care for the uninsured absent the political support needed to create explicit subsidies. Its viability is a function of its low visibility, the collective action problems that dampen payers' political resistance, and the existence of market mechanisms by which individual payers can non-cooperatively escape cost-shifts. To be sure, there are limits to the political (and financial) potential of cost-shifting. The larger the number of payers that contract out of cost-shifts, the smaller the remaining pool that can be tapped to sustain cross-subsidization. As this pool shrinks—and the burden of cross-subsidization falls on a smaller number of insureds and/or their employers—the per capita cost of a given cross-subsidy level rises, prompting more payers to seek contractual means of escaping from cost-shifting, and dissuading some employers and consumers from buying insurance.[254] This combination of the contractual avoidance of cross-subsidy burdens and the decisions by employers and consumers to exit the insurance market places a ceiling on the sustainable volume of cost-shifting. Moreover, as advocates for expanded health care access begin to realize the role that cost-shifting plays in a purchaser's decision to exit the insurance market, policies that promote cross-subsidization could lose some of their current favor among such advocates.

For the time being, however, the political appeal of public policies that rely on cross-subsidization to finance care for the uninsured appears undiminished. Indeed, in 1994, an ideologically diverse group of Congress members embraced a strategy for expanding access to insurance that would achieve federal budget neutrality through a large new cost-shift. This strategy entailed the financing of federal subsidies for the purchase of private insurance through reductions in the growth of Medicare

254. Cost-shifting, in other words, feeds the process of adverse selection. The resulting increase in the number of uninsured persons, and consequently, in the demand for uncompensated care, raises the specter of a destructive, positive-feedback loop. *See infra* notes 259-81 and accompanying text (arguing that cross-subsidization fails to promote the needs of the "beneficiaries" and, instead, distorts the health care and insurance markets).

payments to doctors and hospitals.[255] Unless accompanied by a corresponding decrease in the overall growth of medical spending (an unlikely prospect absent cost control measures more vigorous than those seriously considered in 1994), such reductions would result in further cost-shifting from the Medicare program to private payers. The additional cost-shifting that would result from conditioning the charitable exemption upon provision of free or below-cost care may be modest by comparison.

3. The Case Against Cross-Subsidization

The tolerance for disingenuity that inheres in the case for cross-subsidization is troublesome to the degree that honesty about allocative choices counts as a virtue. If one accords honesty trump value over other concerns about such choices,[256] then policies that promote cross-subsidization as a means of financing free and below-cost care are categorically objectionable. If disingenuity does not rate trump significance—if honesty counts, but not for everything[257]—then an adequate evaluation of policies that promote cross-subsidization requires fuller exploration of its virtues and vices.[258] The solitary virtue of such policies is that just discussed—the superior political viability of cross-sub-

255. *See* Robert Pear, *The Health Care Debate: The Compromise—Diverse Elements Criticize 'Mainstream' Senate Plan*; N.Y. TIMES, Aug. 21, 1994, at A30 (reporting on bipartisan Senate "mainstream" proposal for Medicare and Medicaid cutbacks to finance federal subsidies for people with incomes below 200% of the poverty line).

256. Kant takes the position that truth-telling is an absolute duty and that deception can never be justified by consequentialist arguments. Immanuel Kant, *On a Supposed Right to Lie from Altruistic Motives*, *in* ABSOLUTISM AND ITS CONSEQUENTIALIST CRITICS 15, 15-19 (Joram Graf Haber ed., 1994); *see also* CHARLES FRIED, RIGHT AND WRONG 7-29 (1978) (categorically rejecting consequentialist justifications for lying). Even some utilitarian theorists contend that all forms of deception should be proscribed. *E.g.*, J.J.C. SMART & BERNARD WILLIAMS, UTILITARIANISM: FOR AND AGAINST 82-104 (1973).

257. An expanding literature illuminates the pervasiveness of indirection and subterfuge in the making of allocative decisions. *See generally* CALABRESI & BOBBITT, *supra* note 137. Were one to categorically oppose all allocative mechanisms that employ a measure of disingenuity to circumvent opposition, one would eventually have to reject much of the redistributive activity engaged in by the modern welfare state. The discussion that follows stems from the premise that such absolute insistence on explicitness and directness is, however noble, unrealistic, and that one should weigh disingenuity with other costs and benefits when evaluating subsidy schemes.

258. Such is the case whether one adopts a utilitarian (e.g., economic) model for the evaluation of such policies or whether one pursues some other evaluative approach. Peter Schuck suggests, to the contrary, that economic approaches to the evaluation of subsidy mechanisms must accord trump significance to explicitness. He argues:

sidization by comparison with more visible (and public) redistributive mechanisms. Arrayed against this virtue, I shall argue, are multiple disadvantages. These are understandable in terms of economic efficiency, distributive justice, and moral and political symbolism.

a. *Mismatches Between Resources and Needs*

Most obviously, policies that promote cross-subsidization are poorly targeted to the health needs of those whom advocates of these policies wish to aid. This problem takes several forms, most of which have been addressed elsewhere, and therefore I will discuss them only briefly here. Policies that encourage or require hospitals to provide free or below-cost services will not tend to foster comprehensive health programs for recipients of such services. Absent regulations that specify in detail how cross-subsidy dollars must be spent, hospitals will likely provide the same services they offer to their paying customers. Inpatient care and some outpatient specialty programs are likely to dominate this service mix. Primary care and prevention-oriented programs are likely to be underprovided, relative to inpatient and specialty care.[259] This suboptimal allocation of cross-subsidy funds is the predictable product of institutional inertia: hospitals have no incentive to stray from their usual patterns of production when employing resources garnered via cross-subsidization.[260] In theory, it might be possible to promote a more efficient mix of free and below-cost services by regulating in detail how cross-subsidies are spent.[261] But in practice, such regu-

> [R]ational social choice (if there be such a thing) requires that society decide how it wishes to allocate socially controlled resources in light of its collective purposes .... To the extent that a society conceals from itself both what it wishes to do and what it in fact does, it relinquishes policy control and increases the risk of botching the job.

Schuck, *supra* note 238, at 81. To the economist, however, this hazard is something finite, and to be weighed along with other costs and benefits. These may include the moral price of public disingenuity and the countervailing risk that insistence on explicitness might, via interest group dynamics explainable in terms of public choice theory, yield allocations that do not optimally serve collective purposes (assuming that such purposes are discernible).

259. *See* Schuck, *supra* note 238, at 77 ("If free hospital care is available but free ambulatory care is not, for example, the patient will tend to use the former even if the latter would be superior and less costly.").

260. Since comparable cross-subsidization does not occur for primary care and preventative services provided in non-hospital settings, the beneficiaries of hospital cross-subsidization will tend to have less access to these services than to inpatient and other hospital-based services.

261. Alternatively, one might give hospitals an incentive to pursue an optimal mix of free and below-cost services by requiring them to assume compre-

lation is likely to be exceedingly difficult to fashion[262] and expensive to enforce.[263]

Policies that promote cross-subsidization will also tend to be poorly targeted to the communities most in need of financial support to make medical care accessible. A hospital's capacity to shift costs to private payers will, in general, be inversely related to its proportion of uninsured (and underinsured) patients. Facilities that serve very small numbers of these patients, such as community hospitals in wealthy areas, will on average have an easier time generating revenues in excess of average cost from private payers.[264] Meanwhile, the hospitals most in need of such a surplus—those that treat large numbers of the uninsured and underinsured—will tend to have the most difficulty accumulating it since they have proportionately fewer privately-insured patients to draw upon.[265] This variation in hospitals' cost-shifting needs and capacities creates the potential for a destructive, positive feedback dynamic. Facilities with high indigent care burdens may be unable to offer private payers the

---

hensive responsibility for the health needs of any recipient of free or below-cost care.

262. A regulator would have to conduct a comprehensive, normatively-laden examination of the health needs of each hospital's potential cross-subsidy beneficiaries and of ways in which each facility's resources might be marshaled to meet these needs. The inevitably controversial results of this inquiry would then need to be translated into detailed directives to each hospital. Such comprehensive health service planning via regulatory authority has proven both politically and legally problematic in the U.S. *See, e.g.*, Matt Clark, *Health-Care Battle*, NEWSWEEK, May 28, 1979, at 28 (describing how diverse interest groups successfully defeated a tough 1978 proposed regulatory bill which would have set strict cost increase ceilings as a prerequisite to receiving certain federal funds); CLARK C. HAVIGHURST, HEALTH CASE LAW & POLICY 923-24, 937-66 (Foundation Press, Inc. 1988) (explaining how regulations requiring a certificate of need before constructing an acute-care facility can result in complex and paralytic litigation).

These problems would be compounded if this process were conducted by regulators unschooled in the substance and politics of health care delivery, such as I.R.S. officials charged with administering a charitable exemption made conditional on the provision of free or below-cost care.

263. Enforcement would require extensive monitoring of the range of services provided to cross-subsidy beneficiaries. Moreover, imposing of sanctions on violators would be politically costly for regulators because of the power and prestige of the hospital industry.

264. Exceptions might arise when hospitals that are heavily dependent on one or a few large payers agree because of competitive pressures to discount rates for these payers to levels below average cost.

265. Some jurisdictions have attempted to adjust for this problem by creating uncompensated care pools into which health insurers and self-insured employers must pay via hospital reimbursement surcharges, and from which hospitals with high uncompensated care burdens can obtain disbursements.

same discounts given by facilities with low indigent care burdens. In turn, private payers may avoid high indigent care hospitals, further reducing the ability of these facilities' managers to shift uncompensated care costs.

The problem of poor targeting also appears at a "micro" level, within individual hospitals. Free and undercompensated care requirements impose few constraints on hospital managers' discretion to determine who benefits from cross-subsidies. As Peter Schuck notes, managers obligated to provide a given dollar amount of uncompensated care may be indifferent to the distributional and efficiency implications of decisions about who receives this benefit.[266] Indeed, managers focused on the fiscal well-being of their institutions can be expected to employ cross-subsidies to serve institutional needs at the expense of the financially (and medically) neediest.

They might, for example, engage in only cursory assessment of free-care claimants' financial status so as to minimize the administrative cost of compliance with uncompensated care obligations.[267] Along similar lines, they might represent uncollected accounts receivable from non-indigent patients as charity care to satisfy free care obligations.[268] They might also engage in less-than-zealous debt collection from patients able to pay,[269] figuring that this will lend plausibility to the characterization of bad debt as charity care. To the extent that a hospital can count financially able patients' unpaid debts toward its free and undercompensated care obligations, it can reduce the amount of free care it must provide to the medically indigent. In addition, hospitals that contract for below-average-cost reimbursement from some private payers might try to claim services provided under these contracts as undercompensated care for purposes of compliance with below-cost care obligations.[270] The common effect of these administrative and accounting practices is to chan-

266. Schuck, *supra* note 238, at 77-78 (noting that the hospital need only provide enough uncompensated care to fulfill its obligation).

267. I assume here, as is generally the case for existing uncompensated care obligations, that such administrative costs cannot be counted toward fulfillment of these obligations.

268. Hospital administrators will be facilitated by a lack of consensus among accounting professionals and others regarding the distinction between charity care and uncharitable bad debt. This absence of agreement reflects both the difficulties involved in determining patients' ability to pay and the wide variation in hospital practices with respect to this distinction.

269. Such debts arise largely from unpaid deductibles and coinsurance.

270. *See generally* Sullivan & Moore, *supra* note 11 (describing the problematic nature of free care requirements for tax-exempt hospitals).

nel cross-subsidies away from the financially neediest and toward beneficiaries with weaker claims, such as financially-able deadbeats, patients who misrepresent their economic status, and subscribers to insurance plans that obtain below-average-cost prices. These practices (and this effect) are rendered less visible, and thus more politically viable, by the decentralized nature of the administrative discretion they entail—a factor that contributes greatly to the political feasibility of cross-subsidization as a redistributive technique.[271]

All of these mismatch problems could be ameliorated by public subsidies fashioned to confer health care purchasing power upon needy beneficiaries[272] or upon agents with some incentive to attend to the welfare (however conceived) of such beneficiaries.[273] But even if resources for such subsidies were secured via cost-shifting to private payers,[274] program designers would still confront tasks of explicit, politically visible definition, including specification of eligibility standards and allocation of clinical decision-making authority among consumers, providers, and other parties. To the extent that the political viability of hospital-based cross-subsidization depends on avoidance of such visibility, the above-discussed mismatch problems may be part of the price of feasibility.

b. *Insurance Market Distortions*

Policies that promote cross-subsidization influence the functioning of insurance markets in a manner that leads to adverse

271. *See supra* text accompanying notes 241-46.

272. Such subsidies could take the form of vouchers for the purchase of insurance (or clinical services), tax credits or deductions for medical spending (including the purchase of insurance), or public provision of health services at below-market prices.

273. This paternalistic approach to administering subsidies might take the form of grants to case managers for the purchase of comprehensive care for beneficiaries or enrollment of beneficiaries in managed care plans. One might object to such paternalism and to the risk of managers' less than perfect performance as fiduciaries for their patients, but despite the power of these objections, such managers would seem more likely to pursue some plausible conception of patient well-being than the hospital officials who administer cost-shifting.

274. This could be accomplished in various ways. One option is a tax on hospitals to support public subsidies for the medically indigent. *See, e.g.*, Donald Baker, *Hospital in Alexandria Cited in Wilder's Bid for Tax: Mismanagement Causing Costs to Soar, Government Says*, WASH. POST, Jan. 30, 1992, at B5 (reporting on Virginia's 1992 proposal to levy a tax on hospitals to cover part of the state contribution to its Medicaid obligations). In theory, hospitals themselves could administer such subsidies by, for example, issuing vouchers to beneficiaries for the purchase of health services.

efficiency and distributional consequences. Cross-subsidization burdens private payers in roughly inverse proportion to their ability to exercise monopsony power when bargaining with hospitals. Indeed, payers with sufficient market power may actually benefit from cross-subsidization by negotiating reimbursement rates below hospitals' average costs for some services.[275] So long as a hospital retains enough monopoly power over other payers to burden them with more than their share of its fixed costs, it may be profitable for it to accept below-average-cost payments from a monopsonistic payer. To generate net surplus for the hospital, such payments need only cover the incremental (or variable) costs incurred on behalf of patients insured by this payer, plus any portion of these patients' fixed costs that cannot be shifted to payers with less market power.

Health plans without the monopsony power necessary to strike such deals will pay above-average-cost prices. Payment-to-cost ratios vary enormously among payers,[276] a fact that probably reflects large differences in payers' market power ver-

275. *See* Milt Freudenheim, *To Economists, Managed Care Is No Cure-All*, N.Y. TIMES, Sept. 6, 1994, § A, at 1, 17 (reporting that some managed care organizations pay hospitals less than half of what traditional insurers pay for many procedures and that managed care organizations sometimes obtain across-the-board, below-cost rates from hospitals). The calculation of average costs for hospital services is infinitely complicated by the huge variety of services and the occurrence of many common (or joint) capital and operating costs. *See* Phelps, *supra* note 210, at 117-18 (discussing the complexities of categorizing billable activities and calculating the incremental, common (joint), and average costs). Absent simplifying assumptions, estimation of average costs for hospital services would be impossible. *See, e.g.*, WILLIAM J. BAUMOL ET AL., CONTESTABLE MARKETS AND THE THEORY OF INDUSTRY STRUCTURE 32-36 (rev. ed. 1988). I employ the notion of average cost (and the similarly unrefined concept of incremental or variable cost) in the above text merely to convey, in qualitative terms, the relationship between payers' market power and their prospects for becoming cross-subsidy contributors versus recipients.

276. Insurer-specific payment-to-cost ratios are virtually impossible to come by, since neither payers nor hospitals are inclined to release this competitively sensitive data. Nevertheless, a recent study of payment-to-cost ratios for 58 large, self-insured employers, conducted by a hospital claims data processing firm, finessed this problem by reporting aggregate ratios for groups of employers divided (by ratio) into deciles. Aggregate inpatient payment-to-cost ratios ranged from 1.14 (for employers in the lowest decile) to 1.53 (for firms in the top decile). The study also calculated and aggregated payments and costs for individual inpatient claims, then reported the resulting payment-to-cost ratios by decile. These ratios varied even more widely, from 0.79 for the bottom decile to 2.00 for the highest. OPTIONAL RATES, *supra* note 191, at 87-91 (reporting on study conducted by MEDSTAT, a claims data handling firm, for the Prospective Payment Assessment Commission).

sus hospitals.[277] This variation contributes to inter-firm differences in employee medical spending. These differences, in turn, are reflected in firms' production costs and thus, in the pricing and quality of myriad goods and services.[278] Even without policies that promote cross-subsidization to finance care for the needy, some distortion along these lines would occur due to the just-discussed dynamics of differential monopsony power. But such policies push hospitals to press their monopoly power to its limits, or at least beyond what they might do if driven only by market dynamics.[279]

277. The connection between payment-to-cost ratios and payers' market power over hospitals has not been quantitatively studied. Research along these lines would greatly enhance our understanding of the relationship between payers' market power and hospitals' ability to shift costs. Absent such research, it seems reasonable to infer, from the premise that payers wish to minimize their own expenses, that variation in payer-specific payment-to-cost ratios results from differential market power.

278. The conventional wisdom holds that employers pass all of their fringe benefit costs (including health insurance expenditures) on to their employees in the form of lower wages. *See Clinton Health Care Plan Will Discourage Small Business Job Creation, Says National Small Business United*, PR Newswire Assoc., Inc., Wash. Dateline, Oct. 15, 1993, *available in* LEXIS, News Library, PRNews File (noting that the increased cost of the employee increases incentives to lower wages). Minimum wage laws, according to this conventional wisdom, represent the only constraint on the full pass-through of fringe benefit costs. Consequently, employees who receive wages well above the statutory minimum will bear the entire burden of cost-shifting (or reap the entire benefit of below-average-cost pricing). As wages approach the statutory minimum, some of this burden remains with the employer, but firms can fully adjust for this by reducing the medical benefits they offer.

Thus it would seem, on first inspection, that inter-firm variation in payment-to-cost ratios should not affect firms' total costs of production, or the prices they charge for goods and services. This rationale, however, neglects the effect of such variation on firms' comparative purchasing power in labor markets. All else being equal, competing firms with different payment-to-cost ratios will incur different costs for the same employee compensation package (wages plus medical and other fringe benefits). This cost differential translates into differences in competitiveness that are not related to production efficiency. Managers who confront this competitive disadvantage can either match rival firms' compensation packages and charge higher prices to their customers, or hold down their costs (and prices) by offering compensation packages inferior to those of their rivals. In other words, all else being equal, managers must choose between price and quality disadvantages (assuming that inferior compensation draws lower quality employees). Either way, this market distortion results in social welfare loss.

279. *Cf.* Phelps, *supra* note 210, at 116 (suggesting that American hospitals typically hold unexercised monopoly power, in part because the nonprofit structure legally prohibits the continual accumulation of surplus). The notion that nonprofit hospitals hold unexercised monopoly power is a corollary of the idea, Hansmann, *Nonprofit Enterprise*, *supra* note 9, at 844, that the non-distribu-

In addition to the social welfare loss arising from this economy-wide distortion, cross-subsidization begets adverse efficiency and distributional effects upon medical consumers by discouraging the purchase of insurance. Payment-to-cost ratios greater than one accelerate the dynamic of adverse selection by pushing insurance premiums to levels above those appropriate to risk-pool experience. Some individuals and firms that would, absent cost-shifting, purchase health insurance otherwise will refrain from doing so because of the price distortion created by cost-shifts.[280] This price distortion is likely to be most pronounced for individuals and small employers because they tend to be the least well-positioned to reap the benefits of monopsony power vis-a-vis hospitals. The resulting welfare losses from failure to purchase insurance (that would be rational to buy at prices undistorted by cost-shifting) thus fall disproportionately on employees of small firms and self-employed or unemployed individuals.[281]

c. *Regressivity*

Contrary to common belief,[282] cross-subsidization from private payers is a highly regressive means of financing free and undercompensated care according to the available evidence. A

---

tion constraint reduces the incentives of those in charge of nonprofit institutions to engage in exploitative behavior.

280. Some individuals and firms probably respond to this price distortion by opting for more modest coverage packages than they would choose in a market without cost-shifting. In the case of employer-provided coverage, this response may *enhance* the efficiency of resource use by compensating for excessive spending on health benefits generated by the exclusion of such benefits from employees' taxable income. In effect, the cost-shift (a "hidden tax") functions as a tax on employer-provided health benefits. How precisely cost-shifting compensates for the tax exclusion's effect on the level of employer-provided health benefits is a question without a ready answer. Complicating factors include the wide variation in cost-shifting burdens and uncertainty about the price elasticity of demand for medical insurance at various income levels. For a lucid overview of problems that confound assessment of the efficiency effects of excluding employer-provided health benefits from taxable income, see GENERAL ACCOUNTING OFFICE, REPORT TO THE JOINT COMMITTEE ON TAXATION, U.S. CONGRESS, TAX POLICY: EFFECTS OF CHANGING THE TAX TREATMENT OF FRINGE BENEFITS 71-78 (1992).

281. People with incomes below the poverty line and members of historically disadvantaged minority groups fall disproportionately into these categories. *See* Dorothy P. Rice, *Health Status and National Health Priorities*, 154 W. J. MEDICINE 294, 298-99 (1991) (noting large racial and ethnic disparities in insurance status).

282. *See, e.g.*, Wikler, *supra* note 171, at 139 (asserting that the burden assumed by private payers falls upon the "insured non-poor" and is "progressive with regard to income").

recent study (which this author directed) sought to compare, for six different household income brackets, the proportions of household income diverted by the hospital industry to pay for free and undercompensated care.[283] Because of limitations in the available data, the study looked only at household income channeled to hospitals via consumers' direct payments to hospitals and contributions toward health insurance premiums; employer contributions toward employees' health benefits were not examined.[284] For each income bracket, average direct payments to hospitals[285] and estimated disbursements to hospitals made from consumers' contributions toward insurance[286] were summed, then multiplied by the fraction of private payments to hospitals attributable to cross-subsidization.[287] The resulting figures (the average cost of cross-subsidization to consumers in each income bracket) were divided by the mean pre-tax incomes for each bracket to yield cross-subsidization burdens for households in each bracket, expressed as fractions of mean pre-tax incomes. These fractions were then adjusted to take account of the tax benefits accruing from these cross-subsidization burdens by virtue of the federal medical expense deduction.[288]

The resulting figures sketch a striking profile of tax regressivity. Households earning between $10,000 and $15,000 per year "spent" an average of 0.44% of their income to subsidize free and undercompensated hospital care, compared with only

283. Robert A. Carolina & M. Gregg Bloche, *Paying for Undercompensated Hospital Care: The Regressive Profile of a "Hidden Tax,"* 2 HEALTH MATRIX 141 (1992).

284. The study relied upon data from the Bureau of Labor Statistics' 1988-89 Consumer Expenditure Survey, which reports on per-household consumer spending, including payments to hospitals and health insurers, by income bracket. The Consumer Expenditure Survey neither includes employer contributions toward health insurance as personal income nor counts these contributions as consumer spending. Unfortunately, the study's authors were unable to locate data on the value of these contributions, broken down by personal income bracket. *Id.* at 152-54.

285. Average direct payments to hospitals from consumers in each bracket were taken from the 1988-89 Consumer Expenditure Survey. *Id.* at 152.

286. These disbursements were estimated by multiplying average consumer payments to private insurers (drawn from the 1988-89 Consumer Expenditure Survey) by the fraction of total private health insurance premiums paid to settle hospital claims in 1988, according to American Hospital Association data. *Id.* at 151-52.

287. This fraction (22%) was drawn from a Prospective Payment Assessment Commission study which concluded that hospital revenues received from private payers in 1990 equaled 128% of covered patients' costs (28/128 = approximately 22%). *Id.* at 150-51 (citing OPTIONAL RATES, *supra* note 191, at 40).

288. *Id.* at 148-50, 154-55, 164-65.

0.10% for households earning more than $50,000 per year. For households in the four intermediate brackets ($15,000 to $20,000, $20,000 to $30,000, $30,000 to $40,000, and $40,000 to $50,000) the respective figures were 0.35, 0.26, 0.17, and 0.16%.[289] Since employer contributions toward workers' health benefits were not studied, these numbers present an incomplete picture of the cross-subsidization burden's distribution across income brackets. On the other hand, there is good reason to believe that inclusion of employer contributions would not qualitatively change this picture. Expressed as a percentage of employee compensation, employer contributions almost certainly fall as employee income rises.[290] Assuming that the fraction of insurance premiums channeled toward cross-subsidization remains roughly constant across income brackets,[291] employer contributions diverted to cross-subsidization likely represent a decreasing proportion of employee compensation as income rises.

One might quibble with concerns about regressivity in this context on the grounds that American society tolerates comparable distributive patterns in other cases of corporate and individual giving.[292] As noted earlier, firms and individuals support many activities through charitable contributions that ultimately flow from buyers of goods and services.[293] If spending on a firm's products, as a proportion of personal income, declines with

289. *Id.* at 165 (percentages rounded-off).

290. *Id.* at 153-54 & n.61 (citing employment cost data, broken down by job description, showing that employers make greater contributions, expressed as fractions of mean income for each job description category, toward insurance benefits for workers in categories with lower mean incomes). There are no published data on employer contributions toward health insurance alone, broken down by employee income bracket. *See supra* text accompanying note 284 (explaining that the Consumer Expenditure Survey does not include employer contributions towards health insurance as personal income).

291. *See supra* note 278 and accompanying text (discussing inter-employer variation in payment-to-cost ratios). Although this fraction varies widely from firm to firm, there is no reason to suspect large aggregate variation across income brackets.

292. *See supra* note 223 and accompanying text (discussing the nexus between consumer activity and charitable giving).

293. The fiscal connection between such contributions and revenue derived from market transactions is immediate for donations by business enterprises. The connection is less direct for contributions from individuals, whose philanthropic resources can generally be traced back to sales of goods and services. My point here is *not* that charitable giving necessarily raises market prices. Indeed, corporate giving is often a *substitute* for advertising and other promotional spending, and, as such, affects neither a firm's total cost of doing business nor its pricing policy.

rising income, donations derived from the firm's revenues are open to characterization as a regressive way to pay for the recipients' activities.[294]

A thorough discussion of whether such regressivity is sometimes or always problematic lies beyond the scope of this Article. I limit myself here to the observation that giving by commercial entities is widely lauded and that any associated regressivity is tacitly tolerated. Without casting general doubt on our acceptance of such regressivity, hospital-based cross-subsidization can be distinguished on two grounds. First, the large proportion of private payments diverted by hospitals to finance free and undercompensated care contrasts with the small fraction of total revenues that firms more typically donate to charity.[295] At least arguably, regressive financing of corporate charity is rendered unproblematic by its tiny volume, relative to donors' revenues.[296] Second, hospitals effect cross-subsidization by exercising their market power over private payers.[297] Hence, there may be more reason to look behind the institutional veil to the distributive profile of generosity financed by monopolistic pricing.[298] One important such reason may be the likelihood that

294. *See* Pamela Marin, *350 Make Room for Ronald*, L.A. TIMES, Jan. 21, 1988, pt. 9 at 4 (describing a benefit for Orange County's Ronald McDonald House). A fast food chain that donates money to programs for the families of sick children can be said to finance such programs regressively if the proportion of consumers' incomes spent on fast food declines with rising income.

295. In 1993, U.S. corporations collectively contributed a total of $5.92 billion to charity, approximately 1.3% of their pre-tax profits (and thus a much lower proportion of their total revenues). Jeff Harrington, *Corporate Giving Begins at Home. . . But Should it Stay There?*, CINCINNATI ENQUIRER, Sept. 18, 1994, at H1; *see also* John Oslund, *Top Corporate Givers Unchanged*, MINNEAPOLIS STAR TRIB., Apr. 3, 1995, at 2D (discussing the charitable giving of Minnesota's 100 largest corporations).

296. I am not persuaded that the ratio of corporate giving to donors' revenues ought to be decisive with respect to whether such regressivity should be tolerated; I merely note it as a possible basis for making a distinction.

297. *See supra* text accompanying note 260.

298. This basis for selective attention to regressivity is not limited to hospital-administered cross-subsidization, but encompasses all monopolistically-financed giving. It is linked to the first distinction in that only enterprises with substantial market power are likely to accumulate the funds needed to commit more than a tiny fraction of revenues to charitable activities. Aside from the problem of regressivity, the monopolistic basis of cross-subsidy financing (and the market distortions that result) represents an independent reason for concern about public policies that promote cross-subsidization. *See supra* note 278 and accompanying text (asserting that competitive disadvantages, resulting from inter-firm variation in hospital payment-to-cost ratios, force affected managers to choose between reductions in price or quality, with a resulting loss in social welfare).

giving by monopolistic nonprofit firms represent an *additional* extraction of wealth from customers rather than a *substitute* for advertising or other promotional spending.[299]

4. The Case Against Charity

Beyond the above-discussed concerns about cross-subsidization, the ideal of charity is problematic as a premise for broadening access to health care. Apart from whether the imagery of charity aptly characterizes cross-subsidization, the logic of charity has two troubling aspects.

a. *The Double Edge of Voluntarism*

First, provision of medical care as a matter of charity fits awkwardly with the premise that all persons have a moral claim to such care as a matter of right.[300] The virtues of charity are tied to the voluntariness of giving,[301] which in turn derives moral import from the expectation that giving will better people's lives. If what is given is a universal entitlement (that is, a thing available to all persons from the state as a matter of right), then giving cannot materially affect the lives of recipi-

299. Absent market power, nonprofit firms facing price competition might engage in some reputation-building promotional activities, including the provision of free services. Yet these firms would have to supply such services in lieu of other organizational spending. They could not pass the cost of free services to customers in the form of increased prices (or diminished quality) except to the extent that the reputational effects of such services would achieve sufficient product differentiation to offset adverse price or quality changes.

300. By "right," I refer not only to the idea that all persons are entitled to health care (regardless of ability to pay) but also to formulations that eschew rights language in favor of other ways of saying that every individual has a personal moral claim vis-a-vis society. One need not speak in terms of rights in order to claim an individual entitlement, although the difference between rights talk and other modes of asserting personal entitlement may be largely semantic. *See, e.g.*, John Arras, *Retreat From the Right to Healthcare: The President's Commission and Access to Healthcare*, 6 CARDOZO L. REV. 321, 327-40 (1984) (observing that the formulation chosen by President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research—that society has an "obligation" to provide adequate health care to its members—is open to either strong interpretation as an assertion of individual entitlement or a weak reading as a statement of social duty unaccompanied by personal entitlement). In any event, the proposition that all persons are morally entitled to some basic level of medical care, however defined, is a widely-accepted least common denominator.

301. *See* RICHARD TITMUSS, THE GIFT RELATIONSHIP: FROM HUMAN BLOOD TO SOCIAL POLICY, 209-36 (1971) (arguing that voluntary donation strengthens bonds of community); *see also* WALZER, *supra* note 158, at 93-94 (drawing an analogy between voluntary giving and democratic politics as ways to give "concrete meaning to the union of citizens").

ents,[302] and the act of giving loses its moral force. If the thing that is given *ought* to be a universal entitlement but is not, then charitable provision is at best an imperfect response to social injustice and at worst a self-indulgent diversion from the quest for social justice. Either way, the virtues of charity coexist awkwardly with the claims of justice. Moreover, to the extent that the case for public provision of a thing rests on the general belief that access to it is an attribute of membership in a society,[303] voluntaristic provision of the thing degrades recipients by casting doubt on their belonging.[304]

One response to these concerns about the double edge of voluntarism is that charity care requirements render such care less gift-like and thus less inimical to the idea of health care as a right. This argument has considerable force, given the proliferation of such requirements, and conditioning federal tax exemption upon provision of free or below-cost care would add to this force. Indeed, the accretion of such requirements lends to private giving the color of public provision, effected via state actions similar to regulatory takings. To the extent that this non-voluntaristic picture persuades, the frayed imagery of charity that surrounds cross-subsidization is further undone. Even if one overlooks the non-voluntaristic dynamics of hospital cost-shifting, institutional giving in compliance with the state's mandates and prerequisites hardly seems a matter of generosity.

b. *The Politics of Culpability*

Beyond the awkward conceptual fit between provision of health care as a matter of charity and as a matter of right, the idea of charity works against public support for expanding access to care through the use of public funds. The rhetoric of charity structures listeners' perceptions, inviting people to understand gaps in access to care as a problem to be solved by pri-

302. Private giving in such circumstances will reduce the state's burden, similar to a taxpayer's donation to the IRS in excess of her tax obligation, but it will not affect recipients' access to the thing given. More speculatively, the oft-noted shrinkage of the realm of charity with the rise of the welfare state may be best understood as a consequence of declining opportunities for private donors to materially affect access to life's most basic necessities.

303. *See* WALZER, *supra* note 158, at 64-91 (arguing that societies recognize varying sets of "wants" as "needs" and then differentiate members from non-members through political decisions about the scope of "communal provision").

304. More precisely, the donor's discretion, so critical to the perceived virtue of private charity, itself degrades recipients by rendering their membership less than certain. *Id.* at 62.

vate action rather than public intervention.[305] Promotion of charitable provision casts hospitals as responsible agents, culpable for society's failure to achieve universal access and capable of ameliorating this failure.[306] Were charitable provision able by itself to ensure universal access to care, this turn away from the idea of public responsibility could perhaps be dismissed as a matter of ideological taste. The resources that American hospitals now devote to free care, however, represent only a small fraction of what is needed to achieve universal access to basic care.[307] In view of the growing challenge to the market power of hospitals now being mounted by monopsonistic health care payers,[308] a large increase in the volume of free care provided by hospitals seems unlikely. Indeed, the hospital industry's ability to sustain current levels of free care in the face of private payers' growing monopsony power is doubtful.[309] Thus, the rhetoric of charity represents at best a fractional and, at worst, an illusory answer to our national failure to achieve universal access to health care.

5. Summing Up

For many reasons, the idea of charity is deeply problematic as a way to characterize the financial arrangements by which hospitals provide free and undercompensated care. Nevertheless, a creditable case can be made for the role of charitable imagery in making these arrangements politically palatable. Indeed, these arrangements have proven more palatable than have myriad proposals for the public financing of care for the

305. *See* STEVENS, *supra* note 28, at 319 (discussing the dichotomy between state-mandated and entrepreneurial solutions to the problems of health care access); *see also id.* at 43 (distinguishing voluntarism and charity).

306. Many proponents of charitable provision also hold that public financing of medical services for the needy is necessary to achieve universal access. This Article does not assert that advocacy of charitable provision (as a second-best strategy) is logically inconsistent with advocacy of public financing, but rather that emphasis on hospitals as culpable agents diverts attention from the state's responsibility for our failure to achieve health care access for all.

307. Projections of the additional medical spending necessary to achieve universal access to care vary widely and are a subject of much controversy. However, there is general agreement that coverage for the nation's approximately forty million uninsured would dramatically increase this population's utilization of both outpatient and hospital care. *See generally* M. Susan Marquis & Stephen H. Long, *The Uninsured Access Gap: Narrowing the Estimates*, 31 INQUIRY 405 (1995).

308. *See supra* note 211 and accompanying text.

309. *See* COST SHIFTING, *supra* note 214, at 15 (warning that "cost-shifting's days may be numbered" because of increasing market pressure from price-conscious purchasers).

needy.[310] Such success cannot be lightly dismissed, even if achieved with the aid of a measure of disingenuity. This success rests the best case for conditioning charitable exemption upon the provision of free and undercompensated care, and for other efforts to promote such provision.

However, this case is seriously undermined by the problematic effects of cross-subsidization. Poor targeting of resources to needy beneficiaries, socially wasteful insurance market distortion, and remarkably regressive financing make cross-subsidization inferior to public financing as a means of providing health services to the uninsured poor. In addition, apart from the problems inherent in cross-subsidization, the language of charity is troublesome in its own right. The ideal of voluntarism is inconsistent with moral commitment to a universal, personal entitlement to health care. Moreover, the rhetoric of charity presents the problem of inadequate access to care as a matter of private responsibility. It thereby diverts attention from the political necessity of mobilizing public resources if universal access is to be achieved. The promotion of charity care, via conditions on the charitable exemption or via other regulatory means, is defensible as a last resort, once one presumes that public financing is a political impossibility.[311] So long as public provision remains a serious possibility, however, free and undercompensated care requirements represent a dubious response to the American dilemma of inadequate health care access.

B. Conditioning the Exemption Upon Community Benefit

The 1969 revenue ruling that put an end to the charity care requirement characterized hospital services for paying patients as "beneficial to the community as a whole" even though medically indigent community members do not partake of this benefit.[312] This language had doctrinal significance because the common law of charitable trusts, upon which the ruling purported to rest, required that an activity be found beneficial to the

310. *See supra* notes 234-40 and accompanying text (discussing the interplay between charitable imagery and political exigencies).

311. If one rejects the notion that the state has any obligation to ensure access to medical care for those unable to afford it, the promotion of charity care is defensible in terms of voluntarism. On the other hand, to the extent that the state's promotional activities such as free-care requirements for charitable exemption create economic incentives for "giving," the ideal of voluntarism may be subverted by these activities.

312. Rev. Rul. 69-545, 1969-2 C.B. 117, 118.

community in order to meet the charitable purpose requirement.[313] The ruling's declaration that the provision of care to paying patients and the operation of an emergency room open to all persons as passing the community-benefit test[314] ensured that a finding of community benefit would be automatic for the vast majority of nonprofit hospitals. More recently, however, the Treasury Department has signaled an interest in closer community-benefit scrutiny. A 1983 revenue ruling eliminated the emergency room requirement for some specialized hospitals,[315] yet suggested that "[o]ther significant factors" could serve as community benefit criteria.[316] During President Bush's term, departmental criticism of proposed free-care requirements invoked a variety of community service activities, including health education, screening, and preventative care, as potentially probative of community benefit.[317]

In 1992, the IRS issued new audit guidelines requiring nonprofit hospitals to document the services they provide to their communities.[318] Most recently, President Clinton's ill-fated health reform proposal included language amending § 501 to require exempt medical care providers to annually assess community health care needs and develop plans to address these needs.[319] Nonprofit hospital industry leaders have espoused

313. *Id.* (citing RESTATEMENT (SECOND) OF TRUSTS § 368 cmt. b, § 372 cmts. b-c; 4 SCOTT ON TRUSTS §§ 368, 372.2 (1967)).

314. *Id.*

315. Rev. Rul. 83-157, 1983-2 C.B. 94, 95 (announcing that hospitals offering services "limited to special conditions unlikely to necessitate emergency care" need not maintain emergency rooms). The ruling also stated that general hospitals need not operate emergency rooms when state health planning authorities determine that such facilities would produce unnecessary duplication of services. *Id.* at 94-95.

316. The IRS specified several such factors but left open the possibility of others. The factors identified in the ruling were "a board of directors drawn from the community, an open medical staff policy, treatment of persons paying their bills with the aid of public programs . . . and the application of any surplus to improving facilities, equipment, patient care, and medical training, education, and research . . . ." *Id.* at 95.

317. *See, e.g.*, Treasury Statement, *supra* note 32, at 27 (outlining those factors indicative of community benefit).

318. Announcement 92-83, 1992-22 I.R.B. 59 (instructing auditors to review hospitals' documentation of community service standards).

319. H.R. 3600, 103d Cong., 1st Sess. § 7601(a) (1993). The reform proposals introduced in 1994 by Senate Majority Leader George Mitchell and House Majority Leader Richard Gephardt contained similar language plus a requirement that exempt health care organizations provide "outreach services" pursuant to their assessments of community need. S. 2357, 103d Cong., 2d Sess. § 7301(a)(n)(1)(b) (1994); H.R. 3600, 103d Cong., 2d Sess. § 3685(b)(4) (1994).

such language[320] and have even proposed more detailed community service criteria[321] as an alternative to free-care requirements.[322] Proponents of closer community-benefit scrutiny rely upon two underlying, often vaguely described justifications for exemption: substantive benefits accruing to communities and local participation in planning and governance. Implicit in these justifications is a quid pro quo conception of exemption as something earned via some sort of community service. Neither justification is convincing, for reasons that I will presently review.

1. Substantive Benefits

Aside from the treatment of disease, many kinds of community benefit have been claimed as justifications for charitable exemption.[323] They include the economic impact of hospitals as employers and as purchasers of goods and services[324] and myriad community outreach programs emphasizing health education, diagnostic screening, and other health promotion

320. The Clinton plan's community-needs provision was consonant with similar proposals by nonprofit hospital industry leaders. *See, e.g.*, J. David Seay, *Tax-Exemption for Hospitals: Towards an Understanding of Community Benefit*, 2 HEALTH MATRIX 35, 45-47 (1992) (advocating requirements that exempt hospitals undertake community health care needs assessment, set specific community health improvement goals, and design community benefit plans).

321. Several nonprofit hospital trade associations, including the Voluntary Hospitals of America and the Catholic Health Association, have developed detailed community benefit assessment and reporting programs. *See* Terese Hudson, *Hospitals Strive to Provide Communities with Benefits*, HOSPITALS, July 5, 1992, at 102 (describing hospital-sponsored community benefit initiatives).

322. Industry backers of closer community benefit scrutiny have been candid about their hope that more detailed community benefit reporting will deflect pressure for the institution of free and undercompensated care requirements. *Id. See also* Clark W. Bell, *Hospitals Must Clearly Measure Charity Care and Other Benefits*, MODERN HEALTHCARE, June 22, 1992, at 53 (asserting that hospitals must document their charity programs in order to maintain credibility); Timothy Eckels & Julie Trocchio, *Model Refines Quantification of Community Service*, HEALTHCARE FIN. MGMT., Feb. 1992, at 34-38 (reporting on efforts to quantify community benefits in order to preserve tax exemption); Jay Greene, *Systems' Charity Care Tells Only Part of Story*, MODERN HEALTHCARE, Jan. 11, 1993, at 27 (describing hospitals' untabulated charity expenditures); Karen Pallarito, *Economic-Impact Study Seen as Vehicle to Spur Growth, Deter Tax*, MODERN HEALTHCARE, Dec. 7, 1992, at 38, 39 (maintaining that a loss of tax exempt status would force hospitals to cut their community service expenditures).

323. Arguments to the effect that the provision of medical care to paying patients may justify exemption are considered and criticized above. *See supra* text accompanying notes 14-21.

324. Pallarito, *supra* note 322, at 38-39 (describing results of economic-impact study covering southeastern Pennsylvania).

activities.[325] The economic impact argument is plainly implausible as a basis for exemption because it does not distinguish nonprofit hospitals from for-profit firms (including hospitals) that play large roles in local economies.[326] Community outreach programs present a more difficult question. Such programs may serve marketing and other promotional purposes for hospitals, just as sponsorship of sporting events or the arts does for many for-profit corporations. Distinguishing between commercially inspired outreach activities and those engendered by community-oriented benevolence is complicated by hospital managers' efforts to describe virtually all such activities in the latter terms.[327] It would be overly cynical to ascribe commercial purposes to all community service programs. But the promotional potential of these programs is undeniable. Not only can such activities as health screening and education attract paying pa-

325. Examples of outreach activities cited as grounds for exemption include blood pressure and cholesterol screening, educational efforts aimed at preventing the spread of HIV, immunization campaigns, transportation for patients, housing for families of patients, senior citizen day-care, and even "positive-thinking" classes. *See* GAO Report, *supra* note 51, at 37-43 (summarizing survey results detailing the types of activities hospitals provide as benefits to their communities); Eckels & Trocchio, *supra* note 322, at 36 (giving these and other examples of outreach programs); Hudson, *supra* note 321 (describing hospitals' community benefit programs).

326. Enterprises such as factories, shopping malls, theme parks, and major league athletic teams often receive special tax and other benefits from local governments anxious to attract and keep them. These public subsidies may yield economic development that makes them worthwhile from a social welfare perspective, but such development has never been a basis for federal or state charitable exemption. Singling out the nonprofit hospital industry for special treatment in this regard would represent a radical departure from longstanding tax principles. If federal tax policy favored patterns of economic development affected by the hospital industry, credits and deductions available to both the nonprofit and for-profit sectors would be a more acutely targeted and traditional means.

327. A growing cadre of consultants, attorneys, and hospital trade association officials is urging nonprofit hospital managers to report on outreach activities to tax authorities and the public in non-commercial, community-oriented terms to deflect challenges to tax-exempt status. *See* Eckels & Trocchio, *supra* note 322; Terese Hudson, *Attorney: Business Image Can Hurt Hospitals*, HOSPITALS, Aug. 5, 1990, at 68; Sandy Lutz, *VHA Releases Its Own List of Standards to Help Members Show Value to Community*, MODERN HEALTHCARE, Apr. 13, 1992, at 14. The potential for disingenuity in claims of community-oriented benevolence is driven home by the proliferation of advice to hospital managers urging that community service programs be developed and marketed with an eye to boosting institutional competitiveness by strengthening reputation. *Cf.* Joseph M. Inguanzo, *Communicating Mission: Research is Vital*, HOSPITALS, Aug. 5, 1991, at 45 (urging use of market research and assertive public relations strategies to devise and promote community service programs).

tients directly, they can also enhance a facility's reputation and thereby boost marketing efforts indirectly.[328]

To the extent that community outreach activities are market-driven, they are no more plausible a basis for exemption than are the advertising and public relations efforts of for-profit enterprises. On the other hand, to the extent that outreach programs constitute benevolence beyond that generated by market incentives, they pose many of the issues presented by hospital provision of free and below-cost care. Like free and below-cost care, outreach programs that are not fully financed by fees from users are financed by shifting costs to paying patients.[329] The problems of disingenuity, mismatches between services and need, insurance market distortion, and regressive financing (addressed above in connection with free and below-cost care) make cross-subsidization no less problematic as a way to finance community outreach activities. The above discussions of disingenuity, insurance market distortion, and regressivity are equally germane to all community-oriented programs financed by revenues from paying patients. Problems of mismatch between services and community needs differ only slightly for free care and for community outreach programs.[330] As is the case for efforts to expand access to care, these many difficulties make direct public subsidies preferable to nonprofit sector benevolence as a means of providing community-oriented screening, educa-

328. *See* Inguanzo, *supra* note 327, at 45-46 (describing how communicating a hospital's community programs can boost that hospital's reputation in the community).

329. Some of the cost-shifting that pays for outreach programs can be explained in market terms as investment in product promotion and institutional reputation. My focus here is on cross-subsidization of outreach activities, at higher than market-supported levels, in pursuit of non-market objectives set by hospital managers.

330. The problem of mismatch between cross-subsidy availability and community needs is similar in two contexts; those hospitals most able to afford outreach programs and free care tend to be located in communities least in need of them. *See supra* text accompanying notes 264-65. Also, mismatch problems arising from managerial preoccupation with institutional well-being, and the resulting indifference to other indicia of community need, are similar in both contexts. *See supra* text accompanying notes 262-63. A significant difference, however, lies in the greater importance of marketing and other promotional considerations when hospital managers plan community outreach programs. To the extent that the promotional value of some programs is disproportionate to the need for them (understood from a public health or other, more neutral perspective), promotional considerations may distort the planning of outreach programs, yielding undesirable distributional and efficiency consequences.

tion, and other health promotion programs.[331] Absent the supposition that public subsidies are a political improbability, the case for exemption as a means of inducing private provision of such outreach services is thus weak.

2. Process-Oriented Criteria and Community Participation

An alternative model for closer community benefit scrutiny emphasizes the process of institutional governance. Proponents of this model assert that substantive criteria for community benefit would "devoluntarize" nonprofit hospitals, undermining their distinctive virtues as privately-governed, community-oriented institutions.[332] In place of substantive requirements, advocates of this approach urge the adoption of process-oriented criteria aimed at encouraging facilities to plan for community needs with the participation of community representatives. Central to this model is the premise that institutions rooted in the community can be relied upon to discern and respond to community needs. When joined to community-rootedness, the model holds that voluntarism is desirable both intrinsically and instrumentally (as virtuous in itself and as a means of responding to community needs). Among the process-oriented criteria urged by proponents of this model are community representation on hospital governing bodies,[333] community involvement in the development of plans to meet local health needs, and various reporting requirements for community service programs.[334]

Insofar as this approach rests on the claim that the intrinsic virtues of voluntarism deserve tax exemption, it is unconvincing

331. This conclusion is open to the criticism that processes by which public subsidies are designed are also open to allocative distortion as private actors pursue their own interests through legislative and administrative means. I grant that this criticism has some validity, but the greater visibility of legislative and administrative determinations, in comparison with the decentralized discretion of hospital managers, would result in less such distortion. A comprehensive assessment of the distortions that might affect the design of public subsidies lies beyond this Article's scope.

332. *E.g.*, Seay, *supra* note 320, at 45-46.

333. The audit guidelines issued by the IRS in 1992 include criteria along these lines. *See* Announcement 92-83, *supra* note 318, at 59-60 (instructing IRS auditors to inquire into whether hospital governing boards include local civic leaders and whether minutes of board meetings suggest that such board members play active roles).

334. Seay, *supra* note 320, at 47 (proposing that the IRS inquire into whether hospitals undertake community medical needs assessments, set health improvement goals, involve their communities in the development of plans to pursue these goals, and report on their financial support for community service programs).

for reasons discussed earlier, in connection with the case for per se exemption of nonprofit hospitals.[335] Insofar as this approach relies upon voluntarism's instrumental potential, as a means of engendering private initiative on the community's behalf, it grounds tax exemption based on behavior not readily distinguishable from that engaged in by well-functioning for-profit institutions.[336] As critics of process-oriented criteria have noted, for-profit entities attuned to their markets develop business plans responsive to community needs,[337] at least to the degree that these needs are supported by purchasing power.[338] Where community need is a matter of local knowledge, input from community members is essential to commercial success.[339] For hospitals, as for other enterprises that subsist on revenue from paying customers, the development and implementation of plans to meet local needs are in large measure market-driven. Rewarding such market-oriented strategic planning with tax exemption makes no more sense for nonprofit hospitals than it would for investor-owned entities.

To the extent that such planning is market-driven, exemption in exchange for it constitutes a government give-away, indefensible on quid pro quo or other grounds. To some critics of process-oriented criteria, community-oriented planning by nonprofit hospitals is indistinguishable from market-driven planning by for-profit firms and, as such, plainly does not deserve exemption.[340] Yet reality in this regard may be more complicated. The still-considerable market power exercised by hospitals enables them to channel some resources toward community service activities in accordance with a sense of mission that is not *purely* market-driven. Clearly, the growing market power of

335. *See supra* text accompanying notes 181-86.

336. *See supra* text accompanying note 183 (asking why, on the basis of virtue, exemptions should be restricted to nonprofit hospitals).

337. *E.g.*, John D. Colombo, *Health Care Reform and Federal Tax Exemption: Rethinking the Issues*, 29 WAKE FOREST L. REV. 215, 265 (1994).

338. *Id.*

339. This input can take a number of forms, including the hiring of managers drawn from the community and the use of market research techniques, such as surveys and focus groups. The latter methods, of course, do not entail the sort of community participation in governance envisaged by advocates of process-oriented community benefit criteria for exemption. Yet from an instrumental vantage point, one that values community involvement as a means for devising programs which meet community needs, this difference is unimportant.

340. *See, e.g.*, Colombo, *supra* note 337, at 265 (proclaiming it "somewhat bizarre . . . to base exemption on conduct that for-profit entities must engage in virtually daily as a result of market competition").

health care payers is shrinking hospital managers' residual discretion to pursue non-market purposes. Such discretion, however, remains a fact of hospital economic life, and there is some evidence that nonprofit hospital managers are more inclined than their for-profit counterparts to use it to offer outreach services for low-income people.[341] This evidence hardly suffices to compel the conclusion that community-oriented planning by nonprofit hospitals yields different results than avowedly market-oriented planning by for-profits. Still, it points to the possibility that nonprofit hospital managers employ their monopoly power—and their consequent discretion to pursue non-market aims—on behalf of conceptions of community service distinct from those pursued by investor-owned facilities.

If so, then exemption on the basis of process-oriented criteria cannot simply be dismissed as a give-away to nonprofits for behaving exactly like for-profits as regards community need. Yet the case for process-oriented criteria would be dubious even if it could be clearly shown that some nonprofit hospitals do pursue distinctive, public-regarding conceptions of community need. Scrutiny that focuses exclusively on planning mechanisms and local involvement lacks the fine-grain resolution necessary to selectively reward institutional behavior that is said to justify an exemption on community service grounds. Facilities that conceive of community need in purely market-driven terms can easily portray their strategic planning processes as efforts to discern and address community needs. And community participation, even community representation on governing bodies, hardly immunizes hospital managers from pressures to pursue market-based conceptions of need.

The inability of process-oriented criteria to select for the public-regarding behavior said to justify exemption opens the

341. A national survey of hospitals conducted by the U.S. General Accounting Office found that on average individual nonprofit hospitals provided community outreach services to twice as many people as did similarly sized for-profit hospitals in 1988. GAO Report, *supra* note 51, at 38. Of the 522 facilities surveyed, 68% of the nonprofits but only 39% of the for-profits reported that they "targeted" at least one such service to low-income people. *Id.* at 19, 40. In contrast, nonprofits were more likely than for-profits to recover (by charging fees) the costs of providing particular community services. *Id.* at 38, 42. To the extent that nonprofit hospitals are more inclined than similarly situated for-profits to offer subsidized community outreach services to low-income people, the picture for such services differs from that for subsidized inpatient care. *See supra* text accompanying notes 49-55 (discussing evidence that comparably-situated nonprofits and for-profits provide similar volumes of uncompensated care).

way to pointless give-aways of public resources. To the extent that hospital managers are able to portray market-oriented planning in a manner that meets these criteria, determination of charitable purpose on this basis is functionally equivalent to per se exemption. Attempts to make process-oriented inquiry more discriminating by adding a measure of substantive community benefit scrutiny would encounter the panoply of problems presented by reliance on such benefit.[342] Finally, success in exempting only those hospitals that provide community service beyond that engendered by market forces would reward some facilities for activities they would have undertaken without exemption. Indeed, the marginal spending on community service precipitated by such an exemption might prove small in comparison to total spending on non-market-driven community service,[343] and to the cost of the exemption itself. If so, then even such a selective exemption would represent, for the most part, a give-away from the public fisc.[344]

IV. RECOMMENDATIONS

The multiple rationales for exemption considered above attempt to explain its existence in the current form, and to justify one or another vision of the form that it ought to take. I have argued herein that these rationales fail on both accounts. The Treasury Department's defense of per se exemption as a subsidy for the provision of services that produce positive externalities is equally unsatisfying as a teleological explanation and normative justification. Likewise, the case for per se exemption as a social welfare-enhancing capital subsidy where purchasers cannot monitor outputs is unpersuasive as either explanation or prescription. By contrast, the argument for per se exemption as recognition for the virtues of voluntarism has some merit as an account of beliefs about nonprofit hospitals that have kept the exemption politically viable in its current form. However, recent developments in the hospital industry increasingly strain these beliefs, making the virtue argument less plausible.

Proposals to condition exemption upon the provision of free and below-cost care or other services deemed beneficial to the

342. *See supra* text accompanying notes 318-31.

343. The likelihood that such community service spending is today largely supported by hospitals' market power over payers lends force to this hypothesis.

344. In theory, the give-away component of selective exemption could be eliminated by identifying and rewarding only marginal expenditures on community service induced by exemption. This would be exceedingly difficult to accomplish in practice, however.

community are no more persuasive. A case can be made for returning the exemption to its charitable roots by applying it only to that fraction of a hospital's income traceable to the value of donated resources. This approach, however, would eliminate most of the exemption's value to hospitals, which rely almost entirely on revenues from paying customers. The persistence of the exemption and the reliance on it by powerful institutions invite continued efforts to justify more generous approaches. Such efforts are unlikely, however, to prove more persuasive than those discussed herein, as long as more direct (and precisely targeted) public subsidies for desired activities exist as a viable alternative.

In short, the tax exemption of nonprofit hospitals lacks a convincing justification, either in its current form or as a benefit made conditional upon institutional behavior deemed socially desirable. Nor can the exemption's persistence be plausibly accounted for by the teleological, functionalist explanations considered herein. Yet the exemption has endured, and will probably persist for years to come. Calls for its demise remain beyond the political pale. Free care or community service requirements sufficiently onerous to prompt substantial numbers of nonprofit hospitals to opt out of exemption are almost equally unlikely. The community benefit conditions inserted into several of the leading health care reform proposals in 1993 and 1994 would not have required substantial changes in hospital behavior. On the contrary, they were supported by nonprofit sector advocates with an eye toward relieving pressure for more demanding requirements. As regards the exemption, nonprofit hospitals today constitute a politically potent, actively engaged interest group with inertia of rest on its side.

A. Functionalist Accounts and Structural Constraints

This political reality points to a critical failing shared by functionalist explanations for the exemption's persistence. In postulating that exemption advances some end toward which law or society somehow naturally tends, such explanations disregard the import of structural constraints. Inattention to structural constraint is hardly a categorical sin: proponents of functionalist accounts of legal phenomena can often ignore structural matters without much loss of explanatory power.[345]

345. The economic analysis of law provides many classic examples, such as the disregard of transaction costs that takes place when two well-informed parties bargain over a simple matter, or the disregard of buyers' or sellers' market

However, structural factors loom large with respect to the tax exemption of hospitals. The ability of nonprofit hospitals to influence legislative and agency decision-making is a central factor. The Treasury Department's elimination of free-care requirements in 1969 is directly traceable to industry lobbying efforts,[346] and any serious effort to eliminate the exemption or attach onerous conditions to it would draw formidable opposition from well-positioned industry representatives.[347] Indeed, the persistence of the exemption is probably better explained in terms of models of interest group pressure developed by public choice theorists than by functionalist or teleological theories like those discussed above.

The intensity with which the nonprofit hospital sector defends the exemption reflects not only its economic value, but also the power of settled expectations.[348] Having come over many decades to rely upon the exemption as a stable feature of their fiscal environments, nonprofit hospital managements are loathe to give it up, especially in light of growing insecurity about future revenues.[349] Increasingly monopsonistic and cost-conscious

---

power when market concentration falls below some threshold level. Democratic political theory offers other examples including the neglect of agenda sequencing and cycling problems (of the sort described by Arrow, *supra* note 85) when the outcomes of decision-making processes are being analyzed.

346. *See supra* text accompanying note 12.

347. During the 1993-94 struggle over health care reform, political action committees substantially increased their donations to congressional campaigns. Dana Priest, *Health Plan Worries Spur PACs; Industry Group Donations Up 20%*, WASH. POST, July 14, 1993, at A19 (citing statistics from Consumer Group Citizen Action). The American Hospital Association, representing 5000 hospitals, of which 3100 are nonprofit and 1400 are public, doubled its 1992 contributions to $123,250. *Id.*

348. The significance of settled expectations in this context is an instance of the general observation that persons place a higher subjective value on resources they already possess than on otherwise equivalent resources that they might obtain in the future. *See* PAUL ANAND, FOUNDATIONS OF RATIONAL CHOICE UNDER RISK 3-5, 135 (1993).

349. Insecurity about future cash flow may engender irrationally high industry resistance to the loss of particular subsidies, including tax exemptions, by prompting hospital managers to treat each such potential loss as a broader threat to public support. In effect, skittish managers may react to complex and uncertain fiscal environments by adopting highly simplified decision rules, such as a requirement that any objection to a particular subsidy be taken as a larger challenge to public support. This cognitive response to complexity and uncertainty reflects a number of underlying concerns. These concerns include the costs entailed in making multiple determinations of the importance of resistance and the fear that failure to effectively oppose any particular subsidy loss will be habit-forming, thereby setting the stage for subsequent failure to protect other cash flows. *Cf.* George Ainslie, *Beyond Microeconomics: Conflict Among Interests in a Multiple Self as a Determinant of Value*, *in* THE MULTIPLE SELF

health care payers can hardly be counted upon to cushion hospitals against the fiscal perturbations that would result from elimination of the exemption or attachment of onerous conditions.

The webs of institutional and community reliance on the exemption run deep and wide. Hospitals are large economic players at the local level, both as employers and as purchasers of goods and services from other firms. Thus, the fiscal tremors they suffer send seismic waves through their communities. Such economic shocks are felt with extra intensity in socio-economically marginalized communities, which tend to offer fewer alternative job opportunities to the low-skilled workers that hospitals employ in large numbers.[350] Moreover, where hospitals that teeter on the edge of fiscal oblivion are the sole providers of care for some populations, continued access to care for these populations could depend on survival of the exemption in something akin to its current form.

Thus, the sudden disappearance of the exemption (or the attachment of restrictive conditions) would disrupt current arrangements. Measured against one or another static conception of social desirability, these arrangements seem neither normatively preferable nor teleologically explicable. On the other hand, understood dynamically in terms of the logic of path dependence and structural constraint, these arrangements—and the exemption's current form—make evolutionary sense. Had stringent free-care conditions been enforced early in this century, as nonprofit hospitals were transforming themselves from mostly charitable to largely commercial institutions, use of the exemption might have gradually diminished with little institutional or community disruption. Alternatively, had exemption been withdrawn per se from nonprofit hospitals in the early 1900s as the industry first took on a commercial character, the resulting disruption of arrangements would have been far less than what would occur now, owing to the much-expanded role of health care in our economy today. Our understanding of the exemption's persistence would be much-enhanced by examining nonprofit hospitals' dependence on it over time, their advocacy efforts in Congress and before the IRS, and the extent to which

133, 158-62 (Jon Elster ed., 1986) (proposing that irrationally high valuations of money be understood as the product of "private rules" of perception that link particular gains or losses to longer-term patterns of gain or loss).

350. *See generally* WILLIAM J. WILSON, THE TRULY DISADVANTAGED: THE INNER CITY, THE UNDERCLASS, AND PUBLIC POLICY (1987) (addressing growing mismatch between jobs being created by the U.S. economy and the preparedness of inner-city residents to compete for them).

other important political actors pressed opposing (or sympathetic) views. Such work would shed light on the emergence and operation of structural constraints that have played critical roles in shaping the exemption's evolutionary path.

A historical inquiry along these lines lies beyond my scope here. Nevertheless, an appreciation of the current significance of such constraints points the way toward a pragmatic normative approach to the exemption's future. Such an approach should begin by recognizing that failure to take account of structural constraints when formulating recommendations about the exemption's future is both analytically problematic and politically unrealistic. If scholars are to provide plausible guidance to those with authority over the exemption's fate, they will need to think not only about preferable end states, but also about navigable pathways from present circumstances to desired endpoints.[351]

B. Social Costs, Structural Barriers, and the Future Scope of the Exemption

1. Hospital Services

How should this pathway-sensitive approach play out with respect to the exemption? Rather than assuming an Olympian vantage point with respect to the question of what should be done, I will adopt the situated perspective of a public-regarding policymaker attuned to the costs entailed in surmounting structural obstacles to change.[352] To begin with, such a policymaker ought to recognize that the current per se exemption of nonprofit hospitals cannot be justified absent consideration of structural constraints arising from settled expectations and webs of reliance. Likewise, the case for conditioning exemption upon provision of free care or undersupplied community services is weak,

351. More generally, the tendency of legal scholars to prefer the former sort of inquiry to the latter may limit their impact in fields of regulation within which structural constraints play a large role.

352. Put differently, I assume that policy formulation is a product of both public-regarding efforts and interest group pressures, and that scholarship can contribute usefully to the former by presuming an audience of legislative and administrative actors with public-regarding aspirations, and political and other structural constraints. The hypothetical public-regarding policymaker might sit either within Congress or the Executive Branch, including positions in the IRS, Treasury Department, or White House. Although her institutional authority and political capacities (and vulnerabilities) will differ in these settings, these variations are beyond my scope in this Article. The following discussion applies to both legislative and administrative policy formulation regarding the exemption.

as long as more direct public support for such services remains an alternative. Elimination of the exemption, in short, represents a preferable end state if one disregards the costs of traveling the path from here to there.[353]

On the other hand, these costs are large, and any calculus that neglects them is of doubtful relevance as a guide to action. Legislative or administrative policymakers must spend political capital to counter resistance from potent interest groups committed to the current exemption. For a public-regarding policymaker with limited political capital, payment of this price may be irrational. Progress toward other potential end states, such as universal health care coverage or effective cost-containment, may yield greater social gains per quantum of political cost than would a campaign to end the exemption for nonprofit hospitals. If so, and if a public-regarding policymaker lacks the political capital to achieve these things, then it would be wise for her to defer efforts to end the exemption pending the pursuit of objectives with higher ratios of social benefit to political cost.

In fact, the 1993-94 struggle over health care reform suggests that the ratio of social benefit to political cost entailed in terminating the exemption may be less than it is for other reformist objectives. The current exemption went untouched or only slightly altered in proposals that confronted nonprofit hospitals with such painful prospects as price regulation, Medicare cutbacks, and increased payer monopsony. Faced with a scarcity of political capital, reformers of many stripes may have made a common calculation that challenging the hospital industry on matters central to the design of proposals for enhanced health care access and cost containment was more important than tapping revenues forgone due to the exemption.[354] Calculation of this sort can be rational from a social welfare perspective even when it leads to the survival of policies that seem wasteful from a functionalist vantage point.

This political calculus reflects the patterns of institutional dependence and settled expectations alluded to above. Absent these patterns, nonprofit hospitals and other affected interest groups would not be motivated to channel their limited political assets toward defense of the exemption. To be sure, the link be-

353. The costs referred to here are two-fold: first, the political capital a reformist actor must expend to surmount structural barriers (such as opposition by potent interest groups), and second, the social welfare costs incurred by disruption of settled expectations and arrangements.

354. Alternatively, of course, reformers may have genuinely believed in the exemption's rationality.

tween the social welfare significance of settled expectations and the political power wielded in the exemption's defense is distorted by the kinds of dynamics catalogued in public choice scholarship and other work on collective action. On the other hand, a public-regarding policymaker should keep in mind that political resistance from affected interest groups does, to some degree, reflect concerns that ought to count in the calculus of public interest.

Thus, our public-regarding policymaker should take account of two types of transition costs typically disregarded by commentators who focus on socially desirable ends. At the political process level, she should weigh the costs of challenging adversely affected interests, and she should be prepared to defer pursuit of desirable end results to make wise use of her limited political assets. At the social welfare level, she should keep in mind the transition costs that arise from settled expectations and patterns of reliance. As a practical matter, it will generally be much easier for her to assess costs of the former type than the latter, since self-regarding interest groups are hardly reticent about the political prices they are prepared to exact.[355] As long as political costs at least crudely reflect transition costs arising from settled expectations and patterns of reliance, a calculus that focuses on the political process level can be relied upon to take reasonable account of transition problems. Our public-regarding policymaker should, however, attempt to adjust this politically-based calculus when interest group activity gives short shrift to important social concerns.[356]

For reasons mentioned earlier,[357] this calculus of structural constraint supports the conclusion that an effort to eliminate the exemption would currently be unwise. If, as suggested above, the ratio of social benefit to political cost is lower for efforts to abolish the exemption than for pursuit of some other health policy ends, then these other ends ought to receive higher priority.

355. In contrast, direct assessment of settled expectations and patterns of reliance within an industry or other field of endeavor will usually be difficult (and costly) for policymakers not intimately familiar with the field. This problem looms especially large for economically complex endeavors like health care financing.

356. For example, interest group activity in the health policy sphere can be expected to undervalue the needs of poor and uninsured persons, relative to the concerns of health care payers and providers. A public-regarding policymaker should attempt to compensate for such distortions when addressing problems that bear upon interest group concerns. Pursuing policies that are informed by such adjustments will, however, often prove politically impossible.

357. *See supra* text accompanying notes 345-50.

Given our public-regarding policymaker's limited political resources and our national failure thus far to achieve universal health care access or control of costs, toleration of the current exemption for the time being seems prudent.[358]

On the other hand, elimination of tax exemption for nonprofit hospitals ought to be kept in mind as an ultimate goal.[359] As part of a comprehensive, long-term plan for the reform (and stabilization) of American hospital financing, gradual phase-out of the exemption may someday be possible without sharp disruption of settled expectations and webs of reliance. Such a phase-out would be politically easier to achieve after the implementation of health care financing reforms that leave hospital managers more secure about their future revenues. Universal coverage, for example, would diminish the fiscal vulnerability of hospitals that now serve large numbers of uninsured patients. More generally, reforms that make hospital financing more predictable should reduce managerial anxiety over the loss of particular subsidies.

---

358. Were the IRS (rather than Congress) to discontinue the current exemption for nonprofit hospitals, legislative inaction doctrines could present a legal barrier. Hospitals seeking to challenge their loss of exemption might make two related claims: congressional failure to overturn Revenue Ruling 69-545 constitutes legislative acquiescence to their per se exemption, and that repeated congressional rejection of proposals to tighten requirements for the § 501(c)(3) exemption of hospitals amounted to legislative ratification of per se exemption. Hospitals could buttress these legislative inaction arguments by pointing to their reliance interests in preservation of the per se exemption. *See generally* William N. Eskridge, Jr., *Interpreting Legislative Inaction*, 87 MICH. L. REV. 67, 71-78, 84-89 (1988) (examining the "acquiescence" and "rejected proposal" doctrines). On the other hand, judicial hostility to tax exemptions not explicit in statutory language, along with the principle of broad deference to agencies' statutory constructions, weigh against the possibility that courts might block administrative repeal of the per se exemption by invoking legislative inaction. *See* United States v. Wells Fargo Bank, 485 U.S. 351, 356-59 (1988) (rejecting the argument that Congress's "decision" not to include express limitation of the estate-taxation exemption demonstrates an intent to exempt Appellees's type of property from estate tax, in light of the presumption against implied tax exemptions); Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 865 (1984), *reh'g denied*, 468 U.S. 1227 (1984) (upholding a governmental agency's construction of a statutory provision on the basis that when a construction is permissible, federal judges have a duty to respect the legitimate policy choices of agencies to which Congress has delegated policy-making responsibilities).

359. To avoid breaking with the American tradition of exemption for charitable giving, one might plan on retaining the hospital exemption in fractional form by tying it to the value of donated resources. *See supra* text accompanying notes 184-85, 199-207.

2. Vertical Integration and Medical Risk-Bearing

This pathway-sensitive approach to the exemption points the way toward another, more urgent recommendation. When the future emergence of efficiency-blocking structural constraints can be anticipated, averting such development should be a high public priority. Once patterns of expectation and reliance crystallize around a public entitlement, political resistance to its elimination is likely to be fierce. If, however, the prospect of a new entitlement can be detected before such patterns come into being, the political and social costs of preemptive action are more likely to be manageable.

A rare window of opportunity for such prevention is now open. The American health care industry is in the midst of extraordinary transformation, marked by the advent of myriad organizational forms that integrate the provision and financing of medical services. Large insurers[360] and for-profit hospital chains[361] have played the leading roles in this transformation, developing and marketing institutional arrangements that aim to limit clinical spending via varying combinations of reimbursement rules and provider incentives.[362] In the last several years, however, nonprofit hospitals have begun to respond to this new competitive challenge with integrated health plans of their own. They have joined together with other hospitals and with networks of participating clinicians to offer health care coverage that vies with plans being marketed by more traditional insurers.[363] In so doing, they have sought to expand the reach of the charitable exemption to encompass their risk-bearing activities.

Confronted with the impossibility of arguing that the sale of insurance in itself warrants exemption,[364] advocates for these

360. Erik Eckholm, *While Congress Remains Silent, Health Care Transforms Itself*, N.Y. TIMES, Dec. 18, 1994, § 1, at 1, 34.

361. Bloche, *Corporate Takeover of Teaching Hospitals*, *supra* note 44, at 1078-85 (discussing efforts by for-profit chains during the 1980s to integrate health care delivery and financing).

362. The literature on such arrangements is vast and growing. I shall not attempt to review it here. For a critical discussion of these arrangements and their cost containment potential, see Symposium, *Managed Care: Key to Health Insurance Reform?*, HEALTH AFFAIRS, Winter 1991, at 7.

363. Leading nonprofit hospitals that have begun to develop networks of community hospitals and physicians in anticipation of marketing prepaid coverage include the New York Hospital-Cornell Medical Center and the Columbia-Presbyterian Medical Center. Elsa Brenner, *Moving Ahead at Medical Center*, N.Y. TIMES, Nov. 13, 1994, § 13WC, at 1, 4.

364. A "quid pro quo" argument for exempting nonprofit health insurers might in theory be made based upon the claim that they are less inclined than for-profit health insurers to engage in vigorous risk selection, thereby providing

new, risk-bearing health plans have piggy-backed their case for such expansion on the boilerplate "promotion of health" justification for the exemption of hospitals. They have argued, in the main, that risk-bearing merits exemption because it ensures paying customers' access to care and thereby confers a community benefit. They have also, at times, pointed to research and educational programs conducted by participating hospitals, as well as to free and undercompensated health care offered at these facilities. Thus constructed, the case for exempting risk-bearing activities incorporates all the failings, discussed herein, that beset the case for exempting hospitals.

An early United States Tax Court decision, *Sound Health Ass'n v. Commissioner*,[365] invited nonprofit, risk-bearing health plans to make arguments along these lines. In *Sound Health*, the court invoked the IRS's treatment of nonprofit hospitals to support its decision to confer § 501(c)(3) exemption upon a prepaid health plan. In so doing, the court rejected the agency's contention that the risk-bearing function served by prepaid plans does not further a charitable purpose.[366] The court concluded, in effect, that risk-bearing by health plans is charitable because the provision of medical care is charitable, as per hospital precedent. The court dismissed the IRS's objection that risk-bearing performed for a price benefitted too small a class of persons (the plan's subscribers) to qualify as charitable. On the contrary, said the judges, the class of persons "eligible" to subscribe to the plan—and thereby "*potentially* benefitted" by its risk-bearing function—was "for all practical purposes, the class of members of the community itself."[367] The court finessed the awkward fact that not all "eligible" persons could afford to sub-

---

a measure of public benefit beyond that generated by for-profit insurers. Yet even assuming that aggressive medical risk selection is socially undesirable (a proposition not without controversy, though I believe it to be correct) this argument founders on the reality that vigorous risk selection by some drives similar behavior by all. Insurers that fail to match their competitors' risk selection efforts will be stuck with more expensive risk pools (and higher prices for equivalent coverage) that undermine their efforts to maintain their market share. For-profit and nonprofit insurers alike have been caught in this downward risk selection spiral. *See* HENRY J. AARON, SERIOUS AND UNSTABLE CONDITION 8-37 (1991). Indeed, recognition that for-profit and nonprofit health insurers do not differ in this regard played an important role in Congress's 1986 decision to eliminate the tax exemption of Blue Cross and Blue Shield plans. Tax Reform Act of 1986, Pub. L. No. 99-514, § 1012 (b)(1), 100 Stat. 2085, 2391-92 (1986) (codified at 26 U.S.C. § 833 (1988)).

365. 71 T.C. 158 (1978), *acq.* 1981-2 C.B. 2.

366. *Id.* at 189-91.

367. *Id.* at 185 (emphasis added).

scribe by pointing to the IRS's treatment of nonprofit hospitals: "If the charitable hospital can, except for emergency cases, restrict its treatment to paying patients, [a prepaid health plan] should be able to restrict itself to paying members."[368]

The plan at issue in *Sound Health* was a staff-model HMO—a single corporate entity that employs health care providers, delivers clinical services, and bears financial risk. Myriad other institutional forms that link the financing and delivery of health care are now being developed and marketed. Whether the courts will go along with industry efforts to apply *Sound Health* to these new risk-bearing and managed care arrangements is an important and unanswered question.

Two years ago, the U.S. Court of Appeals for the Third Circuit made an initial foray into this unmapped territory. To the consternation of advocates for risk-bearing, nonprofit plans, a Third Circuit panel declined to extend the *Sound Health* approach. The panel held, in *Geisinger Health Plan v. Commissioner* ("*Geisinger I*"),[369] that risk-bearing on behalf of subscribers able and willing to pay did not by itself satisfy the charitable purpose requirement. The prepaid plan at issue in *Geisinger I* neither employed health care providers nor delivered clinical services. Rather, it contracted with separately incorporated entities, such as hospitals, clinics, and pharmacies, for the provision of services to plan subscribers. On the other hand, the plan and these separately incorporated contractors were affiliates of a single, umbrella entity—the Geisinger Foundation—created to oversee their operation as parts of a coordinated health care system.[370] Nevertheless, the court considered the plan's risk-bearing and health care purchasing activities as a venture distinct from the actual provision of health services. The court thereby averted the force of hospital precedent and the implication that medical risk-bearing must be charitable. Without openly disapproving of the holding in *Sound Health*,[371]

368. *Id.* at 187.

369. 985 F.2d 1210 (3rd Cir. 1993) [hereinafter *Geisinger I*], *aff'd*, 30 F.3d 494 (3rd Cir. 1994) [hereinafter *Geisinger II*].

370. *Id.* at 1213. The Geisinger Foundation, a nonprofit firm, controlled all of these affiliated entities, principally through its power to designate their directors. *Geisinger II*, 30 F.3d 494 (3rd Cir. 1994). The Foundation organized the prepaid plan as a separate corporation (rather than as a component of one of the entities that delivered health services) in part to escape the need to comply with certain state regulations. *Id.* at 497.

371. The Third Circuit panel construed the holding in *Sound Health* as the HMO in question benefitting a large enough class of persons to satisfy the community-benefit test for charitable exemption, resting on the HMO's operation of

the court opined that medical risk-bearing for a price "benefits no one but . . . subscribers," and thus fails to benefit a large enough class of persons to qualify as charitable.[372] The court said the same about health care purchasing by a prepaid plan on its subscribers' behalf.[373]

The Third Circuit thereby departed sharply from *Sound Health* with respect to the § 501(c)(3) treatment of medical risk-bearing. Yet *Geisinger I* left a doctrinal opening for plans that bear risk but do not themselves provide health services. Rather than merely dismissing the petitioner's bid for charitable exemption, the court remanded the case to the United States Tax Court for a determination of whether the plan at issue qualified for exemption as an "integral part" of a qualifying service delivery system.[374] The court characterized the "integral part doctrine" as "a means by which organizations may qualify for exemption vicariously through related organizations, as long as they are engaged in activities which would be exempt if the related organizations engaged in them, and as long as those activities are furthering the exempt purposes of the related organizations."[375]

On remand, and in a subsequent appeal to the Third Circuit, Geisinger Health Plan asserted that this formulation required its prepaid plan to be treated as though it were part of one of the care-delivering entities in the Geisinger system.[376] Geisinger Health Plan relied upon *Sound Health* for the proposition that the health care financing functions performed by the prepaid Geisinger plan should be exempt if so treated. Both the United States Tax Court and the Third Circuit rejected this argument, albeit on different doctrinal grounds. In *Geisinger II*, the tax court held that the prepaid plan would produce unrelated business income if absorbed by one of the Geisinger sys-

---

a subsidized dues program, provision of some free care, and conduct of research and educational programs. *Geisinger I*, 985 F.2d at 1219. The *Sound Health* court's stated basis for its holding, however, was broader; the court clearly stated that the offering of a medical risk-spreading plan to all persons able to pay benefited a large enough class to satisfy the community benefit standard. *Sound Health*, 71 T.C. at 185. This permissive stance was plainly at odds with *Geisinger I*'s negative view of risk-bearing.

372. *Geisinger I*, 985 F.2d at 1219-20.

373. *Id.* at 1220.

374. *Id.* at 1221.

375. *Id.* at 1220.

376. *Geisinger II*, 30 F.3d at 498-99.

tem's care-providing entities.[377] On appeal, a Third Circuit panel charted a more circuitous doctrinal path. Declaring that "we are not bound by the description of the integral part doctrine set forth in *dicta* in *Geisinger I*,"[378] the court announced a further condition: the "relationship" between the entity at issue and an exempt organization must "somehow enhance" the former's "own exempt character to the point that, when the boost provided by the [latter] is added to the contribution made by the [former], the [entity at issue] would be entitled to § 501(c)(3) status."[379] The panel then held that Geisinger's prepaid plan failed to meet this requirement. The plan's link to Geisinger's hospitals and clinics supplied no "boost," the court said, because this relationship did not "increase the portion of the community for which [the plan] promotes health—it serves no more people as a part of the [Geisinger] System than it would serve otherwise."[380]

As an empirical matter, this last claim rests on uncertain ground. Quite possibly, the integration of health care financing and delivery within a single system can achieve efficiencies that enable a plan not only to expand its market share but also to draw previously uninsured consumers into the medical services market.[381] Nonetheless, the practical effect of *Geisinger II*, in tandem with *Geisinger I*, was to caution risk-bearing, nonprofit health plans that the easy route to exemption mapped out in *Sound Health* had become an uncertain proposition.

To be sure, the Third Circuit panel in *Geisinger II* avoided the destabilizing effects of an open repudiation of *Sound Health* by eschewing the Tax Court's characterization of risk-bearing as an unrelated business. Had the Third Circuit endorsed this characterization, the nonprofit, staff-model HMOs that now rely on *Sound Health*'s treatment of medical risk-bearing as charita-

377. Geisinger Health Plan v. Commissioner, 100 T.C. 394, 404-06 (1993). The United States Tax Court reasoned that the plan's coverage of health services provided by non-Geisinger system entities would require treatment of the plan as an unrelated business, were it to be absorbed by one of the system's hospitals or clinics.

378. *Geisinger II*, 30 F.3d at 499.

379. *Id.* at 501.

380. *Id.* at 502. The Third Circuit panel thereby avoided addressing the merits of the United States Tax Court's determination that the plan would generate unrelated business income if absorbed by one of the Geisinger system's hospitals or clinics.

381. The question of whether some integrated financing and delivery systems achieve efficiencies not attainable when insurers and health care providers transact at arms length is a matter of intense dispute, and is beyond the scope of this Article. The readiness of the *Geisinger II* court to presume its own answer to this complex question is both surprising and disheartening.

ble when performed by firms that integrate health care financing and delivery would have confronted the threat of loss of exemption. By taking a different doctrinal track, the Third Circuit managed to preserve *Sound Health* as precedent for an established industry sector—nonprofit, staff-model HMOs—while declaring its intention to deny exemption to an emerging sector: prepaid, managed plans created by nonprofit health care providers as organizationally distinct entities. Taken together, *Geisinger I* and *Geisinger II* stand for the proposition that medical risk-bearing should not be treated as a charitable endeavor, at least when engaged in by organizations that do not themselves deliver health services.

Whether the Third Circuit's approach will be adopted in other circuits remains, as of this writing, a matter of speculation.[382] Assessed in terms of analytic clarity, the conclusory doctrinal formulations relied upon in *Geisinger I* and *Geisinger II* hardly make for a model worth emulating.[383] Yet the *Geisinger* results are consistent with the approach urged in this article: strategic tolerance for existing patterns of expectation and reliance, conjoined with preemptive action to arrest the development of such patterns when their future emergence, can be foreseen. By leaving the holding in *Sound Health* intact as regards staff-model HMOs, *Geisinger I* and *Geisinger II* avert the disruption of settled expectations within an established market sector. By declining to exempt risk-bearing by more loosely integrated health plans like the entity at issue in the *Geisinger* series, the Third Circuit's approach, if widely adopted, would forestall the development of a wasteful new entitlement before its would-be beneficiaries come to rely on it. Failure to act preemptively along these lines would allow the development of structural constraints (arising from patterns of reliance) that would make future elimination of this entitlement politically and socially more costly.

382. As of the beginning of 1995, *Sound Health*, *Geisinger I*, and *Geisinger II* represented the only judicial statements on the federal tax treatment of risk-bearing by nonprofit health systems that integrate financing and service delivery.

383. To be sure, the Third Circuit's reliance upon such unrevealing terms as "exempt purpose" and "promotion of health" reflect the centrality of these terms in established doctrine. The court's failure to set forth a plausible analytic basis for its choices between boilerplate formulations, however, rendered the Geisinger opinions disappointingly opaque. Moreover, *Geisinger II*'s convoluted "boost" test could give rise to yet another tangle of unrevealing doctrine.

The IRS and reviewing courts should thus seize the opportunity for prevention offered by the process of integration that is today transforming the health care industry. The charitable exemption should not be expanded to encompass the risk-bearing activities of the new, still-emerging generation of provider-sponsored, integrated health plans. The outcome of the *Geisinger* litigation points in the right direction in this regard.[384]

CONCLUSION

The current federal tax exemption of nonprofit hospitals is neither explicable nor justifiable in terms of the logic of efficiency or reward for virtue. Proposals to condition the exemption upon provision of free care or community services are likewise poorly supported by efficiency, distributional, or other moral arguments. The persistence of the exemption today, and its probable survival for the foreseeable future, are best explained in terms of the combined logic of interest group politics and structural constraint, tied to patterns of expectation and reliance. To avoid painful transition costs (both political and social), the federal government tolerates a wasteful tax expenditure.

Absent such structural barriers, immediate elimination of exemption for nonprofit hospitals would be desirable. Given the reality of these constraints, the exemption's demise is implausible as a near-term goal, but phase-out of the exemption ought to be a long run tax (and health) policy aim. Elimination of the exemption would be made less costly, both politically and socially, by stabilization of today's chaotic health care financing environment. In particular, guaranteed universal coverage would make hospitals in socio-economically distressed areas less vulnerable to the fiscally disruptive effects of the exemption's demise. Meanwhile, in the near term, the IRS and reviewing

384. There is room for argument over whether the approach advocated in this article counsels tolerance, for the time being, for the exemption enjoyed by nonprofit, staff-model HMOs. On the one hand, as noted above, these entities constitute an established market sector with a reliance interest in the exemption dating back at least to the *Sound Health* ruling. On the other hand, the ongoing rapid growth of this sector makes its continued exemption an increasingly expensive proposition. The political and social costs of terminating the HMO exemption today would be considerable, but they should be balanced against the prospect that failure to do so could lock in an escalating, wasteful entitlement to public resources. This complex calculus of present versus future costs is inherently subjective and open to dispute. Its emphasis on institutional realities, however, distinguishes it favorably from the boilerplate formulations endemic to the law governing exemption of health care organizations.

courts should eschew industry efforts to broaden the exemption to encompass the risk-bearing activities of integrated health care financing and delivery systems. The rapid proliferation of such systems today makes this a critical period in the development of the tax policy and law that affects them. By denying exemption for medical risk-bearing before patterns of expectation, reliance, and structural constraint crystallize, the IRS and the courts can avoid locking in a wasteful, potentially huge new federal entitlement.

Academic models of the exemption have not paid sufficient heed to structural limitations of the sort that have decisively shaped its evolution in the health care context. These models tend toward functionalist explanation—toward the interpretation of existing institutional and doctrinal forms as optimal (or at least good) adaptations to some simple and elegant purpose. This characteristic is shared not only by the economic models considered herein but also by accounts of the exemption as a moral just desert for institutional virtue. Indeed, it is arguable that the aesthetic preference for functionalist elegance within the academic community has engendered a market failure of sorts as regards the explanatory power of scholarship on this subject.

Interpretive accounts that are more attentive to the development of structural barriers and to their blocking effects upon functional adaptation would enrich our understanding of myriad legal and institutional forms that defy efforts to infer purpose. Scholarly efforts along these lines might also contribute more to the achievement of desired functional adaptations than the preoccupation with the search for social purposes served by current arrangements.